STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155359	A. BUILDING 00 B. WING	09/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERBEND HEALTH CARE CENTER	7519 WINCHESTER RD FORT WAYNE, IN 46819

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Recertification and State Licensure Survey. This visit was done in conjunction with the Investigation of Complaint IN00182857. Complaint IN00182857 - Substantiated. Federal/State deficiency related to the allegations is cited at F353. Survey dates: September 17, 18 21, 22, 23, 24, & 25, 2015 Facility number: 000250 Provider number: 155359 AIM number: 100289980 Census Bed Type: SNF/NF: 28 Total: 28 Census Payor Source: Medicaid: 27 Other: 1 Total: 28 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement by the provider with the statement of deficiencies. This Plan of Correction is prepared and/or executed because it is required by provision of Federal and State regulations.	

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

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	QR completed on September 29, 2015 by 17934.			
F 0246 SS=E Bldg. 00	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on interview and record review, the facility failed to provide showers as scheduled for 4 residents (Resident #16, Resident #36, Resident #14, and Resident #32) of 5 residents who met the criteria for choices. Findings include:	F 0246	1.Facility reviewed shower schedule and preference for times and days of showers for residents 16, 36, 14, and 32. Requests were updated on each resident's plan of care and facility shower schedule. 2.All residents will be reviewed for preference of shower and/or	10/25/2015

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	1. Review of the clinical record for Resident #16 on 9/22/15 at 9:00 a.m., indicated the following: diagnoses included, but were not limited to, schizophrenia, depressive disorder, bipolar disorder, and hemiplegia (paralysis). Resident #16 was interviewed on 9/18/15 at 8:35 a.m. During the interview he indicated he could choose between a shower, a bath, or a bed bath, but he had only been receiving showers every 2 weeks instead of 2 showers per week as he was scheduled. A shower schedule for Resident #16 posted in the South Shower Room, indicated he was to receive showers on Wednesday and Friday. A Compressed ADL (Activities of Daily Living) report for Resident #16, dated January 1, 2015 through September 23, 2015, indicated he received showers on: 1/12/15, 1/14/15, 1/16/15, 1/28/15, 2/9/15, 2/23/15, 3/9/15, 4/15/15, 4/22/15, 4/29/15, 8/10/15 and 9/16/15. A facility care plan for Resident #16, with a review date of 8/27/15, indicated the problem area of self care deficit and inability to complete self care task		bath schedules, with noted revisions to their plan of care and shower schedule. 3.Nursing staff will be in serviced on policy and procedures for bathing and/or showering residents, including review of resident's shower schedules. CNAs will notify the charge nurse of resident refusals, if any. The charge nurse will encourage residents to allow staff to assist with care. The charge nurse will document shower given and/or refusal on shower sheet. Director of Clinical Services (DCS) or designee will audit all residents' bathing/shower records M-F to ensure residents receive shower and/or bathing as scheduled. 4.DCS or designee will complete audits weekly for 4 weeks, then 2 times monthly for 2 months, then monthly for 2 months. Audits and corrective action will be reviewed in by Quality Assurance (QA) committee monthly. Continued auditing and/or corrective action will be determined by QA committee.	

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	independently. Approaches to the problem included, but were not limited to, set-up bathing and hygiene supplies in easy reach, showers per schedule, praise resident for any attempts at self-care, and allow sufficient time for completion of task. LPN #7 was interviewed on 9/24/15 at 9:35 a.m. During the interview she indicated the Compressed ADL reports were primarily used for Minimum Data Set assessment information. 2. On 9/21/15 at 10 a.m. the clinical record of Resident #36 was reviewed. The MDS (Minimum Data Set) assessment, dated 6/11/15 included, but was not limited to, the following: independent cognition; personal hygiene required limited assistance and physical assistance of 1 required in part of bathing. On 9/23/15 at 11 a.m., Resident #36 was interviewed. He indicated he does not get at least two showers a week. He indicated he does not receive bed baths and when he doesn't get a shower, he doesn't get cleaned up at all. On 9/23/15 at 3:25 p.m. the Administrator, Assistant Director of Clinical Services (ADCS) and RDCS (Regional Director of Clinical Services)			

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	were interviewed. They indicated residents were to get two showers and/or baths a week. On 9/23/15 at 3:30 p.m. the Administrator provided a copy of the facility policy and procedure for "Bathing/showering" dated 11/30/14. The policy included, but was not limited to, the following: "Assistance with showering and bathing will be provided at least twice a week and prn (as needed) to cleanse and refresh the patient...Document in the medical record." At this time, the Administrator also provided a copy of the Weekly Shower Schedule for the West Hall. This schedule indicated Resident #36 was to be showered on Monday and Thursday on evening shift. On 9/24/15 at 9:50 a.m. LPN #7 provided copies of resident #36's ADL(Activities of Daily Living) reports from May 2015 to September 2015. The report included, but was not limited to, the following numbers of showers documented in the following months in 2015: 2 showers in May; 1 shower in June; 3 showers in July; 6 showers in August; 3 showers from 9/1/15 to 9/22/15. On 9/24/15 at 3 p.m. the Administrator provided a copy of the "Nurse Tec			

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	(Technician) Information Kardex" for Resident #36. The Kardex included, but was not limited to, the following: "Bathing: shower, bath days: Monday and Thursday, evening shift." 3. On 9/21/15 at 11 a.m. the clinical record of Resident #14 was reviewed. The MDS dated 7/21/15 indicated severe cognitive impairment, and total dependence for personal hygiene. On 9/23/15 at 9:50 a.m. the ADL report for Resident #14 was received from the LPN #7. This report indicated the resident received the following number of showers in the following months in 2015: 1 shower in May; zero showers in June and July; 3 showers in August and 1 shower in September from 9/1/15 to 9/22/15. The Weekly Shower Schedule for the west hall was received from the Administrator on 9/23/15 at 3:30 p.m. This form indicated Resident #14 was to receive showers on Mondays and Thursdays on second shift. The Nurse Tech Information Kardex for resident #14 was received from the Administrator on 9/24/15 at 3 p.m. The Kardex included but was not limited to the following information: Bathing,			

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	shower on Wednesday and Saturday.4. During an interview with Resident #32 on 9-18-2015 at 11:26 a.m., the resident indicated some weeks she did not get any showers and sometimes only received one shower per week. Resident #32 indicated staff had told her she couldn't get a shower because there was not enough help. The resident indicated she should get a shower this day (Friday). During an interview with Resident #32 on 9-24-2015 at 12:00 p.m., she indicated she did not get her shower last Friday as scheduled. A review of the clinical record for Resident #32 indicated diagnoses included but were not limited to diabetes, right above the knee amputation, anemia, congestive heart failure and hypertension. A review of the the West Hall weekly shower schedule provided by the Administrator on 9-23-2015 at 3:30 p.m., indicated Resident #32 was to get her showers on Tuesdays and Fridays. The ADL (Activities of Daily Living) report provided by the MDS (Minimum Data Set) nurse on 9-24-2015 at 9:50 a.m., indicated since 7-27-2015 Resident #32 was recorded to have a shower on 8-4-15, 8-7-15, 8-11-15, 8-13-15, 2015			

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	and 9-4-15, 9-15-15 (twice) and on 9-22-2015. A Nurse Tech Information Kardex provided by the ADCS (Assistant Director of Clinical Services) on 9-24-2015 at 4:25 p.m. for Resident #32, indicated for bathing the following was checked: "...Shower, Assist of 1, Shampoo w/bath, Bath Days T (Tuesday), F (Friday), Shift E (Evening)...." A care plan dated 8-7-2015 and provided by the ADON on 9-24-2015 at 4:25 p.m. for Resident #32, indicated the resident was at "...risk for further loss of ADL self sufficiency due to Rt AKA (right above the knee amputation)...." The goals indicated "...Staff to assist resident as needed with daily activities...." with interventions to "...assist resident with personal care as needed, set-up supplies, allow adequate time for resident to complete tasks...." The Administrator was interviewed on 9/24/15 at 10:20 a.m. During the interview she indicated the Certified Nursing Assistant (CNAs) were to give residents their showers per the shower schedule. She also indicated the CNAs were then to report to the Nurses when the showers were given and the Nurses			

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	were to follow-up to make certain the residents did receive their showers as scheduled. 3.1-3(v)(1)			
F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by			

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	the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on record review and interview, the facility failed to ensure contractures were identified during the admission nursing assessment and during the MDS (minimum data set) assessment period for 1 of 5 residents who met the criteria for range of motion. (Resident #52) Findings include: 1. The clinical record of Resident #52 was reviewed on 9/23/15 at 9 a.m. Diagnose's included but were not limited to, the following: severe mental retardation. The admission MDS dated 7/30/15 included, but was not limited to, the following: no impairment to upper extremity (which included wrist and hand) either side. The MDS dated 8/6/15 also indicated no impairment to either side of the upper extremity. The Admission Data Collection form, dated seven 7/23/15 included but was not limited to, the following: for "functional status", "contractures, site, degree" was left blank. On 9/21/15 at 9:45 a.m., the resident was observed ambulating in the hall independently. Her right hand was	F 0272	1.A modification MDS was completed on resident 52 by the MDS coordinator, which identified impairment to residents' right hand. No other physical impairments were identified. Therapy evaluated resident for R hand impairment. 2.All residents will be re-assessed for functional status. Needs identified will be addressed by IDT, recorded on each resident's MDS, and updated on each residents' plan of care, as applicable. All MDSs will be reviewed to ensure each the MDS reflects the functional status of each resident. 3.Licensed nurses will be in-serviced on Comprehensive Assessments and Admission Data Collection upon admission. DCS, MDS Coordinator, or designee will audit new admission records M-F. Assessments will be reviewed M-F by the IDT for treatment and plan of care. 4.Audits of newly admitted resident's records will be completed on new admissions M-F by DCS or designee, and will continue as an ongoing QA measure to ensure resident's needs are addressed and the MDS accurately reflects the residents' functional status.	10/25/2015

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	observed in a clenched position. The 4 fingers of her right hand were observed to be touching the base of her right palm and her wrist was in a flexed position, towards her inner arm. On 9/23/15 at 2 p.m.,(Certified Nursing Assistant) CNA #1 was interviewed. She indicated Resident #52 did have a contracture to her right hand. On 9/23/15 at 3:40 p.m., the ADCS (Assistant Director of Clinical Services) observed Resident #52. She was observed laying in her bed and the ADCS attempted to assist the resident to open the fingers of her right hand. The resident was observed to have her right hand in a closed position with the right fingers down touching the right palm base. The ADCS indicated the resident moved the right thumb freely. She indicated the resident was able to open her right fingers away from her right palm, but not entirely and not freely. The ADCS indicated the Resident #52 did have impairment to her right hand. The ADCS indicated she was unable to locate a documented assessment of the resident's right hand having had an impairment. The ADCS indicated there was no documentation of the impairment in the chart at this time that she was able to find.			

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	An Interdisciplinary progress note, dated 9/23/15, included but was not limited to, the following: "Assessed resident's R (right) hand...writer spoke with guardian stated that her hand has been "exactly like that" for 13 years. Guardian stated "she had 6-7 fractures et (and) surgeries in the course of a few years...Will request PT (physical therapy) eval (evaluation) et tx (treatment) for contracture..." This entry was signed by the ADCS. On 9/23/15 at 3:50 p.m., the Administrator was interviewed. She indicated she had talked to LPN #7, also the MDS (Minimum Data Set) Coordinator and she indicated the MDS did not show an impairment of the resident's right hand/wrist. On 9/24/15 at 11:26 a.m., LPN #7, the MDS coordinator was interviewed. She indicated when she gathers information to complete the resident's MDS, she reviews documentation and also observed the resident. She indicated this resident's right wrist/hand contracture, "just got missed" on the MDS. On 9/24/15 at 11:46 a.m., the Administrator provided a current copy of the facility policy and procedure for MDS, dated 9/1/15. The policy included,			

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	but was not limited to, the following: "...Policy: The facility should conduct a comprehensive, standardized...assessment of each resident's functional status and need using the federally and/or state required RAI (Resident assessment instrument) assessment as required by regulations...Each individual who completes a portion of the assessment will sign and certify the accuracy of the portion that was completed...." On 9/24/15 at 12:15 p.m., the resident was observed in the dining room at the table. The resident was observed to keep her right hand in a clenched fist closed in her lap with the right wrist in a flexed position. The resident was observed to pick up her beverage mug, which was placed on the right side of the resident's plate, with her left hand. At 12:19 p.m., the resident received her tray. She continued to keep her right hand clenched in her lap. She was observed to hold her silverware, which was placed on the right side of her plate, with her left hand. She continued to keep her right hand in her lap underneath the clothing protector. The resident was observed to feed herself with a spoon in her left hand. She kept her right hand in her lap beneath her clothing protector.			

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	3.1-31(d)(1)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to provide a therapeutic diet as ordered for 1 resident (Resident #C) and also failed to decrease an anti-depressant medication as ordered for 1 resident (Resident #16) of 28 residents reviewed for physician orders. Findings include: 1. Review of the clinical record for Resident #C on 9/21/15 at 8:37 a.m., indicated the following: diagnoses included, but were not limited to, profound intellectual disability, anxiety state, attention deficit with hyperactivity, mood disorder with psychotic features, phenylketonuria (inborn error of metabolism) (PKU) , aphasia, and dysphagia. A Nutrition Follow-up Note for Resident #C, dated 7/8/15, indicated he received the nutrition interventions of: Pureed diet	F 0282	1.Clarification of therapeutic diet order for Resident #C was reviewed by the physician, ADCS, and RD. Clarification of diet order was received by physician for mechanical soft diet with thin liquids. Orders were updated on resident's plan of care, including dietary communication to reflect on residents' tray card for each meal. Resident #16 was assessed without adverse effects or changes in mood. Physician and RP were notified with new order to decrease to Zoloft to 75mg on 9/24/2015. Pharmacy was notified;orders were transcribed to residents #16 MAR, and administered as ordered. 2.All residents' physician orders, including medication and diet orders will be reviewed for the past 90 days to ensure plan of care is being followed per MD order. 3.Staff will be in serviced on facility policy on therapeutic diets and physician orders, including dietary notification and physician orders are transcribed to MAR as	10/25/2015

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	with nectar thick liquids, no protein at breakfast, no artificial sweeteners, no caffeine, no chocolate, 1/2 portion of protein at lunch and supper, and give double bread, starch, vegetable and fruit at all meals. A physician's order for Resident #C, dated 8/18/15, indicated to discontinue Pureed diet and begin Mechanical Soft diet. A physician's order for Resident #C, dated 8/27/15, indicated to discontinue nectar thickened liquids and begin thin liquids. Physician orders for Resident #C, dated for the month of September 2015, indicated the following dietary order: Mechanical Soft diet with thin liquids, no protein at breakfast, no artificial sweeteners, no caffeine, no chocolate, 1/2 portion of protein at lunch and dinner, double bread, starch, vegetables, fruit, and dessert at all meals, double bread/pastry at breakfast, and cereal x (times) 2 at breakfast. During an observation of the lunch meal on 9/22/15 at 12:15 p.m., Resident #C was observed seated in a chair at the dining room table. He received a Mechanical Soft diet consisting of		noted. 4.DCS or designee will review all new physician orders daily M-F, including dietary recommendations. DCS or designee will audit resident records and plan of care to ensure care plan is revised and notifications are made to dietary, pharmacy, etc. Audit of physician orders will continue M-F as an ongoing quality assurance measure. Results of audits will be reviewed monthly by QA committee for corrective action as indicated by QA committee.	

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	ground meat, bread/butter, mashed potatoes, peas and carrots, and mixed fruit salad. The portions he received were the standard serving size. There were no double servings of vegetables, bread, potatoes, or fruit. During the meal he was provided an extra serving of ground meat by LPN #12. Review of his tray ticket indicated he received a Mechanical Soft diet with a divided plate and padded utensils. The tray ticket did not indicate he was to receive double portions of vegetables, fruits, starch, and bread at all meals and 1/2 portion of protein at lunch and supper. During an observation of the breakfast meal on 9/23/15 at 8:14 a.m., Resident #C was observed seated at a dining room table. He received a Mechanical Soft diet consisting of scrambled eggs, an orange muffin, and hot cereal. The portions he received were the standard serving size. There were no double servings of the muffin or hot cereal. Review of his tray ticket indicated he received a Mechanical Soft diet with a divided plate and padded utensils. The tray ticket did not indicate he was to receive double portions of the cereal and muffin or he was not to receive any eggs. During an observation of the lunch meal on 9/23/15 at 12:11 p.m., Resident #C			

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	was observed seated at a dining room table. He received a Mechanical Soft diet consisting of chili mac, cornbread, small chopped salad, and ice cream. The portions he received were the standard serving size. There were no double servings of the salad or cornbread. Review of his tray ticket indicated he received a Mechanical Soft diet with a divided plate and padded utensils. The tray ticket did not indicate he was to receive double servings of cornbread and salad. A facility care plan for Resident #C, with a review date of 7/20/15, indicated the problem area of nutritional risk related to mechanically altered, chewing problem, swallowing problem, cognitive loss, behavioral problems, therapeutic diet, and mental retardation. Interventions to the problem included, but were not limited to, diet as ordered, (Mechanical Soft Low Protein Diet with thin liquids), no chocolate, no caffeine, no artificial sweetness, double starch, vegetables, fruit, dessert at meals. The Certified Dietary Manager was interviewed on 9/24/15/ at 10:30 a.m. During the interview he indicated he was not aware of the dietary restrictions for Resident #C.			

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	The Regional Dietary Clinician was interviewed on 9/24/15 at 12:20 p.m. During the interview she indicated when Resident #C's diet order was changed from pureed consistency to mechanical soft consistency, all the dietary restrictions related to his PKU were to be removed as well. She also indicated changing the texture of his diet would have changed all the restrictions as well. 2. Review of the clinical record for Resident #16 on 9/22/15 at 9:00 a.m., indicated the following: diagnoses included, but were not limited to, schizophrenia, depressive disorder, bipolar disorder, and hemiplegia (paralysis). A physician's order for Resident #16, dated 7/18/15, indicated to discontinue Zoloft (anti-depressant) 100 mg (milligrams) and to start Zoloft 75 mg daily for depression. Review of the Medication Administration Records for Resident #16, dated for the months of July, August, and September 2015, indicated he continued to receive Zoloft 100 mg daily. A facility care plan for Resident #16, with a review date of 8/27/15, indicated the problem area of resident is at risk for			

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	side effects from antidepressant medication use. Interventions to the problem included, but were not limited to, administer medication as ordered by physician. The Assistant Director of Clinical Services was interviewed on 9/23/15 at 10:30 a.m. During the interview she indicated the physician's order to decrease the Zoloft for Resident #16 had been missed. A current facility policy "Physician Orders", dated 11/30/14 and provided by the Assistant Director of Clinical Services on 9/23/15 at 10:30 a.m., indicated "...A Clinical Nurse shall transcribe and review all physician orders in order to effect their implementation...." 3.1-35(g)(2)			
F 0332 SS=D Bldg. 00	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%.	F 0332	1.Residents #18, 35, and 36 were assessed without adverse outcomes. Physician and responsible party were	10/25/2015

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	This involved 3 of 6 residents observed in the medication pass (Residents#18, Resident #35, Resident #36) and involved 1 of 4 nurses observed to pass medications. (LPN #9). Findings include: 1. On 9/22/15 at 4:15 p.m., LPN #9 was observed to obtain Resident # 18's blood sugar using his glucometer. The resident was observed to be sitting in his recliner in his room. She obtained a blood sugar result of 293 mg/dl (milligrams/deciliter) At this time, she referred to the MAR (medication administration record) and indicated the resident was to receive 30 units of Novolog insulin. At 4:23 p.m., LPN #9 was observed to draw up and administer 30 units of Novolog insulin to Resident #18. She indicated the evening meal was to be served at 6 p.m. The MAR of Resident #18 was reviewed at this time and indicated the resident was to receive 30 units of Novolog 100 units/ml (milliliter) for a sliding scale coverage result of of 293 mg/dl. The MAR indicated the sliding scale blood sugars were to be done "before meals and at bedtime." The MAR listed the following times for the blood sugar checks to be completed: 6 a.m., 11 a.m., 4 p.m., and 8 p.m.		notified. Physician orders were reviewed and updated on each resident's plan ofcare. 2.All residents' physician's orders will bereviewed to ensure medication administration times are according to physicians orders. Updates will be made on each resident's plan of care according to physician orders. 3.LPN #9 will be re-educated on facility policy and procedures for physician orders, medication administration, and prevention of medication errors. All licensed nurses will be re-educated on facility physician orders, medication administration, and prevention of medication errors. DCS or designee will complete a medication pass observation with LPN #9, and audit all residents' Medication Administration Records weekly to ensure medications are given as ordered. DCS or designee will observe medication administration passes for 2 nurses on each shift per week until all nurses have been have observed without medication errors. 4.DCS or designee will audit MARS weekly for 8weeks, then 2 times per month for 8 weeks, then monthly for 2 weeks, then quarterly times 2. DCS or designee will report results of MAR audits and medication observation passes to QA monthly.QA will review audits monthly and determine corrective action.	

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On 9/22/15, the resident was observed at 4:50 p.m., 5:15 p.m. and 5:40 p.m. in his recliner in his room and was easily aroused with no complaints. The resident was observed to receive his meal in the dining room after 6 p.m.

On 9/22/15 at 5:10 p.m., the ADCS (Assistant Director of Clinical Services) was interviewed. She indicated the resident's blood sugars tend to run high and the resident does well with his insulin dosages.

2. On 9/22/15 at 4:30 p.m., LPN #9 was observed to prepare medications for Resident #35. LPN #9 indicated the resident was to receive 2 tablets of 20 mg (milligrams) tablets of Isosorbide (blood pressure medication), for a total dose of 40 mg. However, LPN #9 was observed to only dispense one 20 mg tablet into the resident's medication cup. The MAR was reviewed at this time and indicated "Isosorbide 20 mg, give 2 tablets (40 mg) 2 times a day." LPN #9 picked up the resident's medication cup and indicated she was ready to administer the medications to the resident. At that time, LPN #9 was asked how many pills she had to give to Resident #35. LPN #9 counted the pills in the resident's medication cup and she indicated she had

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	7 pills. After counting the number of pills from the MAR that should have been administered, LPN #9 was made aware she only dispensed one tablet of Isosorbide. She indicated she didn't dispense two of the Isosorbide pills as she should have. At this time, LPN #9 dispensed another Isosorbide pill to give to the resident. Resident #35 did receive the correct amount of Isosorbide. 3. On 9/22/15 LPN #9 was observed to give Resident #36 his Metformin (anti-diabetic medication) at 3:50 p.m. At the time the resident received his medication, he was not observed to be eating. On 9/22/15, the resident was observed to receive his tray after 5:45 p.m. The MAR of Resident #36 was reviewed and indicated Metformin 500 mg was to be given twice a day for diabetes. The time listed on the MAR for the medication to be administered were at 8 a.m. and 5 p.m. On 9/23/15 at 9:25 a.m. the RDCS (Regional Director of Clinical Services) provided a copy of the meal times for the facility. This was dated effective 2013. Breakfast was listed at 8 a.m., lunch at 12 noon and dinner at 6 p.m.			

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	On 9/23/15 at 9:28 a.m., the RDCS provided a copy of the current facility policy for "Insulin Administration" dated 11/30/14. This policy included, but was not limited to the following: "The clinical nurse will administer insulin...per physician's order." On 9/24/15 at 4:23 p.m., the ADCS was interviewed. She indicated it was the facility's expectation that fast acting insulins, such as Novolog, be given within 15 minutes before a meal. She also indicated it was the facility's expectation the acceptable time frame to obtain a blood sugar prior to administering insulin would be within 30 minutes. She also indicated the physician orders for Resident # 35 should have been followed in regards to the correct dose of the medication being administered. She indicated Resident #36's Metformin should have been administered with a meal. On 9/25/15 at 11:31 a.m., Medical Records LPN provided copies from the facility's reference book, the 2103 Nurse Drug Handbook, which was located at the nurses station. This book indicated the following: Metformin (diabetic medication) had the following directive for administration: "Give drug with meals." Novolog insulin (regulates			

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	glucose metabolism) had the following directive for administration: "Give Novolog 5 to 10 minutes before start of a meal. 3.1-25(b)(9)			
F 0353 SS=F Bldg. 00	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed to ensure nursing staff provided the necessary care	F 0353	1.Resident C was assisted by nursing staff at 9:25pm on 9/21/2015, who were completing resident care in another room on South Hall. The other licensed nurse and CNA on duty were	10/25/2015

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	and services to meet the needs of the residents who resided in the building. This had the potential to affect 28 of 28 residents residing in the facility. Findings include: During an observation on 9-21-2015 at 9:15 p.m., Resident C was observed walking down the East hall in a hospital gown (with the back open), an incontinence brief and bare feet towards the nurses station. The bed alarm was heard sounding in the hallway. Resident C grabbed a surveyor's arm with a tight grip and another surveyor's hand. The bed alarm continued to sound and no staff were visible or able to be located in any of the hallways. After 10 minutes, 2 staff appeared from South hall and assisted Resident C. The two staff from the West hall were not able to be located during the entire time the alarm was sounding. An observation of the nurse staff posting on 9-21-2015 at 9:30 p.m., indicated 2 LPNs (Licensed Practical Nurse) and 2 CNAs (Certified Nursing Assistants) were on duty for the 2nd shift (3:00 p.m. to 11:00 p.m.) An observation on 9-21-2015 at 9:58 p.m., indicated the West hall nurse left		providing care to other residents on West Hall. 2.All residents will be reviewed for care needs and nursing assignments will be adjusted to ensure at least one staff member is present at nurses' station, in hallways, or within distance to hear and respond to resident alarms, call lights, etc. to the meet the needs of residents. 3.Nursing staff will be in-serviced to ensure staff is present at nurses' station, in hallways, or within distance to hear and respond to resident alarms, call lights. Etc. Interdisciplinary team members, including the Administrator, DCS, and department directors, will provide staff support daily, from 12p to 8p to assist with call lights, meal service, and resident requests. IDT members will notify nursing staff of direct patient care needs. 4.Administrator or designee will conduct 5 resident and staff interviews per week for 4 weeks, then 2 times per month x 2,then 3 monthly x 3; to determine if residents and staff are meeting the needs of residents. IDT will conduct rounds M-F to ensure residents care needs are addressed. Facility will continue recruitment andretention of nursing staff through use of human resource programs, community advertisements, etc. Results of interviews, rounds, and Human Resource efforts will be	

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	the building. The 3rd shift nurse was not observed to have arrived, leaving only one nurse in the building. During the annual survey from 9-17-2015 through 9-25-2015, confidential interviews with residents deemed interviewable by the facility indicated the following concerns from individual residents: "Staff short on weekends" and resident indicated not getting showers per schedule. "Not enough staff after lunch until supper" and the resident indicated having incontinence accidents because it took staff 30 to 45 minutes to answer the call light. The resident also indicated "not getting showers because there was not enough help." The resident indicated this past weekend there was not enough staff and dinner was late on Sunday evening as it was not served until 6:30 p.m. The resident indicated there was not enough staff to assist for toileting during mealtimes. This resident indicated "short staffed all the time. Staff will answer call light, turn if off and say they will come back, but don't come back. Had to wait an hour and a half for staff to change brief." The		reviewed monthly in QA. QA will determine corrective action and the need for continue monitoring.	

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	resident indicated this past weekend, management staff had to come in to provide care for residents. This resident indicated "short staffed on 2nd and 3rd shift and has had to wait several hours" for staff to put resident to bed. The resident indicated this past Sunday, they did not get dinner until 7:30 p.m. and evening medications were not passed until 11:00 p.m. This resident indicated "has had to wait for call light to be answered, short staffed on night shift and shorter on weekends." The Resident indicated when the Administrator and RNs leave, the staff were more "lax." This resident indicated in regards to staffing, "it depends if staff comes in." This resident indicated after a fall it took 10 minutes for staff to respond. This resident indicated over the weekend something was going on Saturday with staffing as morning medications were not passed until evening. A family member of a resident indicated when looking for staff for another resident, no staff members were found at the nurses station or in the hallways. The			

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	family member indicated staff do not answer call lights. Confidential interviews with staff who provided care for residents indicated the following: "The facility works short. They try to replace staff who call in but can't always find replacements. Several residents require 2 person assists for lifts and transfers." Another staff member who provides care for residents indicated 2nd shift has been short staffed frequently. A staff member who provides care for residents indicated the sounding of an alarm would mean the resident got up and staff was to try to get to the resident as soon as possible. The staff member indicated there had been times when care was being provided for another resident and the staff member was unable to get to the resident whose alarm was sounding. Another staff member indicated the facility was "very short of staff on Sunday the 20th. No one was available to pass the meal trays. The Director of Clinical Services (DCS) was supposed to work, but called in."			

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	On 9-22-2015 at 9:35 a.m., Social Services provided a list of 10 residents which were deemed interviewable. On 9-22-2015 at 11:40 a.m., the MDS (Minimum Data Set) nurse provided a list of 8 residents who required 2 staff for transfers. An interview with the ADCS (Assistant Director of Clinical Services) on 9-23-2015 at 9:25 a.m., indicated it was determined that the evening shift needed a manager in the building to ensure things were getting done and to monitor the activity and attitude of the staff. The ADCS indicated she usually worked from 5:00 p.m. to 1:30 a.m., but since the DCS had been off with her vision problems, she had been covering days. The ADCS indicated all positions were scheduled for Saturday, 9-19-2015 and Sunday 9-20-2015 until a Certified Nursing Assistant (CNA) called off for a double shift (days and evenings). The ADCS indicated the night CNA called off. The ADCS indicated the DCS came in to cover from 7:30 a.m. to 2 p.m. (the paper schedule indicated until 1:30 p.m.) Actual punch times for facility staff who worked on 9-20-2015 and 9-21-2015 were provided by Human Resources on 9-22-2015 at 9:30 a.m. The punch times			

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	were reviewed and did not indicate the DCS had punched in for her shift. An interview with Human Resources on 9-22-2015 at 10:15 a.m., indicated the Managers did not use the time clock. She indicated the Managers included the Administrator, DCS, ADCS, and Social Services. Human Resources also provided 2 time clock adjustment forms for a staff member for worked times on 9-19-2015 and 9-21-2015. Human Resources indicated the staff member did not clock in or out on her shifts and the times would have to be entered manually. There was a discrepancy in the paper form dated 9-21-2015 and the actual end time observed on 9-21-2015. An updated, clearly written staffing schedule was provided by the ADCS on 9-22-2015 at 11:25 a.m. A review of the updated staff schedule with the actual time punches were reviewed with discrepancies noted. The Saturday schedule indicated the DCS worked until midnight. The Saturday schedule indicated the Administrator worked from 12 a.m. to 6 a.m. on Saturday morning. An observation of the Medical Records LPN on 9-23-2015 at 10:10 a.m., indicated she was passing ice water in the West hall. She indicated she was helping			

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	out the aides. An observation of the Medical Records LPN on 9-24-2015 at 8:48 a.m., indicated she was passing medications to residents in the East hall. The Medical Records LPN indicated she was filling in for someone who did not show up. An observation on 9-24-2015 at noon indicated the Medical Records LPN was passing the noon medications to residents in the East hall. During an interview with the Administrator, the Regional Director of Clinical Services and the ADCS on 9-24-2015 at 9:30 a.m., they indicated the DCS was in the building as the aide until midnight on both Saturday 9-19-2015 and Sunday 9-20-2015. The Administrator and ADCS indicated the DCS was working as the only aide after 6:30 p.m. on Sunday evening until midnight. Further interview with the Administrator indicated she came in Sunday night and assisted with getting residents to bed. The staffing information previously provided by the ADCS did not indicate the Administrator was in the building on Sunday evening. The Administrator indicated she did not know what time she was here and she indicated she did not enter any documentation on the care she			

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	provided. A current policy, "Staffing" dated 11-30-2014 was provided by the Administrator on 9-25-215 at 12:45 p.m. and indicated "...Staffing will be maintained by the facility in accordance with State and Federal Requirements. The facility will have appropriate staff to provide for the needs of the residents at all times...." This federal tag relates to Complaint IN00182857. 3.1-17(a)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to maintain a clean and sanitary kitchen. The facility also failed to ensure staff washed their hands for the recommended amount of time, after touching soiled	F 0371	1.A deep clean of the kitchen areas was performed by the dietary staff to address areas noted in the dry store room and kitchen. The splash guard to the garbage disposal will be replaced. 2.Kitchen renovation will be completed, including replacing tile	10/25/2015

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	objects and before assisting residents to eat. The facility further failed to ensure food for residents was protected from potential contamination. This deficient practice had the potential to effect 28 of 28 residents who consumed food and beverages prepared by the facility. Findings include: 1. During the initial tour of the facility kitchen on 9/17/15 at 9:40 a.m., the following was observed: The floors in the dry storage area were dirty, with dried dirt and debris observed caked around the legs of the shelving units, as well as along the baseboards under the open shelving units. Drywall was missing from the corner of the storeroom. Dried dirt and debris were also observed along the baseboards in the kitchen and around the legs of the equipment. The baseboard along the wall next to the large cooking equipment had shrunk away from the tile on the floor, leaving a 1 inch gap of dirt and debris. There were large gouges and cracks in the kitchen flooring, and cracked tiles under the large cooking equipment, the dishmachine area, and under the ice		floor, storage closet door, base boards, drywall repair and painting. 3.All staff will be in-serviced on hand washing and infection control. Dietary staff will be in-serviced on dietary cleaning schedules. Maintenance Director will be re-educated on infection control measures and maintenance repairs related to food services and sanitation. 4.CDM or designee will conduct daily rounds to ensure food is stored and prepared correctly and to ensure cleaning schedules and tasks are followed. Maintenance director will complete weekly rounds in the dietary department for 4 weeks, then monthly x 2, then quarterly x 2. Results of rounds will be reviewed monthly inQA by the committee. QA will determine the need for continued monitoring or corrective action by the Maintenance.Daily rounds will continue by CDM or designee as an ongoing QA measure.	

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	machine. There were holes in the drywall leaving exposed metal stripping visible in the outer corners of the walls in various areas of the kitchen. There was peeling paint on the wall above a food prep table, and paint was peeling underneath the fan in the walk-in cooler. A large wet area was observed on the floor of the walk-in cooler and a plastic basin full of water was on an open shelving unit underneath the fans. A temporary piece of flexible material was thumbtacked to the wall behind the ice machine. When the thumbtacks were removed, the flexible material came away from the wall, exposing large holes in the dry wall. A sheet of wall board next to the 3-compartment sink had pulled away from the wall. Food particles and debris were observed in the channels surrounding the grease trap in the floor. The baseboards along the hallway where the walk-in cooler and the walk-in freezer were located had separated from the wall.			

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	There were holes in the outer corner of the drywall by the coffee machine and holes in the wall behind the coffee machine. The door to the chemical closet was rusted at the bottom. The splash guard in the disposal was black around the edges and shredded into pieces. The staff were observed to place a plastic lid from a nearby garbage can over the disposal when it was running to prevent food and liquid from escaping the disposal. The Certified Dietary Manager (CDM) was interviewed on 9/17/15 at 10:00 a.m. During the interview he indicated he had only been back in the facility for 3 weeks. The CDM was interviewed on 9/22/15 at 2:05 p.m. During the interview he indicated the problems in the kitchen had been noted by himself and by the Registered Dietitian. He also indicated their reports concerning the needed repairs had been provided to the facility administration. Maintenance was interviewed on 9/23/15 at 1:40 p.m. During the interview he indicated the holes in the wall behind the ice machine were caused by moisture leaking from the bottom of the ice machine due to rust on the outside			

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	bottom panel. He also indicated the wall became wet and deteriorated the drywall. 2. During an observation of the lunch meal in the dining room on 9/17/15, the following was observed: At 12:00 p.m., Certified Nursing Assistant (CNA) #1 was observed to pour drinks into 2 handled plastic mugs with flow control lids for a resident seated at a dining room table. She was observed to place the lids on the cups by pressing down on the lids with the palms of her hands touching the drinking spout. At 12:04 p.m., LPN #2 was observed to lather her hands with soap for 9 seconds prior to rinsing. She was then observed to assist with the meal service. At 12:07 p.m., Administration was observed to lather her hands for 13 seconds prior to rinsing. She was then observed to prepare beverages for residents to drink. At 12:17 p.m., LPN #3 was observed to wash her hands for the recommended amount of time. She then sat down next to a resident placing her hands in her lap, with her hands touching the slacks of her uniform. She was observed to pick up the resident's silverware to pick of bites			

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	of food from her plate and then placed the silverware in the hands of the resident. She was not observed to re-wash her hands after they touched the slacks of her uniform. At 12:19 p.m., LPN #3 remained seated next to the same resident. She was observed to touch her face with her hands and also touch her hair. She also shook hands with the resident. She continued to assist the resident by picking up bites of food with the resident's utensils and began feeding her. She was not observed to re-wash her hands. At 12:20 p.m., LPN #1 was observed to lather her hands with soap for 9 seconds prior to rinsing. She then continued with meal service. 3. During an observation of the lunch meal in the dining room on 9/22/15 at 12:03 p.m., Maintenance was observed to enter the dining room and place a clean clothing protector on a resident. He was not observed to wash his hands prior to handling the clean clothing protector. 4. During an observation of the lunch meal in the dining room on 9/23/15, the following was observed: At 8:05 a.m., Administration was			

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	observed to pick up pieces of paper from the floor in the dining room. She then was observed to lather her hands for 13 seconds prior to rinsing. She then assisted with meal service. At 8:08 a.m., Human Resources #4 was observed to wash her hands the entire time under running water. She then assisted with meal service. At 8:11 a.m., Administration was observed to lather her hands with soap for 17 seconds prior to rinsing. She then continued to assist with meal service. 5. During an observation of the kitchenette adjacent to the therapy department on 9/23/15 at 1:45 p.m., 2 trays of baked iced cupcakes, a total of 48 cupcakes, were observed on top of the counter. The cupcakes were not covered to protect them from possible contamination. Registered Physical Therapist #5 was interviewed on 9/23/15 at 1:45 p.m. During the interview he indicated the cupcakes were prepared by the Activity Department to be served at the resident birthday party in the afternoon. 6. An observation of the hall trays being passed on 9-17-2015 from 12:01 p.m. - 12:18 p.m., indicated the following:			

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	CNA #8 entered room 118 with a meal tray, placed the tray on the overbed table and used her hands to move the overbed table near the resident. The CNA did not don personal protective equipment which was observed in the hallway outside of the room door. The resident in the room was on isolation precautions. CNA #8 delivered a meal tray to room 129. The CNA was observed to move with her hands a wheelchair, overbed table, CDs off of the overbed table and adjusted the hand crank of the bed. Without handwashing or performing hand hygiene, CNA #8 was observed to unwrap all the plastic coverings from the dishes and cups on the tray. The CNA unwrapped the plastic from the bread and held the bread with the plastic on the bottom in her hand and spread the butter on the bread with a knife, and salted the resident's food. CNA #8 obtained a tray for room 132 and set the tray on the overbed table. Hand hygiene or handwashing was not observed and CNA #8 obtained another meal tray from the cart and delivered it to the resident in room 134. The CNA was observed to unwrap all the food coverings from the dishes and cups and unwrapped the silverware. CNA #8 was			

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	observed to unwrap the plastic from the bread and held the bread with the plastic still on the bottom in her hand and buttered the bread with a knife. At 12:12 p.m., CNA #8 was observed to leave the east hall and used the hand gel on the wall in the east hall and performed hand hygiene. The CNA continued to the dining room, obtained sugar packets and was observed to hand to the resident in room 131. Without handwashing or performing hand hygiene, the meal tray for room 132-2 was obtained from the tray cart and set on the resident's overbed table. Handwashing was then observed for 15 seconds in the resident's bathroom. After handwashing, CNA #8 used the hand control to raise the resident's bed, moved a pillow on the chair next to the bed with her hand and then unwrapped the silverware, uncovered the hot food on the tray and began feeding the resident her meal without performing hand hygiene or handwashing. An observation of the hall tray meal service on 9-21-2015 at 11:54 a.m., indicated Social Services pushed the meal cart down the South hall to room 127. Social Services was observed to cough into her right hand. Without handwashing or performing hand hygiene, Social Services opened the meal			

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	tray cart, obtained a meal tray for a resident and carried the meal tray with her hands into the resident's room. The Certified Dietary Manager (CDM) was interviewed on 9/24/15 at 11:00 a.m. During the interview he indicated staff were to lather their hands for 20 seconds before rinsing and staff were to re-wash their hands after handling soiled objects and before handling a resident's eating utensils. He also indicated staff were to wash their hands prior to feeding a resident and were to re-wash their hands if they touched any soiled objects while feeding the resident. He further indicated staff were to place a lid on a drinking mug without contaminating the spout and the cupcakes baked in the therapy kitchenette should have been protected from contamination. A current facility policy "Cleaning Schedules", dated 11/30/14 and provided by the Regional Director of Clinical Services on 9/23/15 at 2:00 p.m., indicated "...The Dietary Department will adhere to cleaning schedules to maintain a clean and sanitary department and prevent the growth of bacteria..." A current facility policy "Hand Washing Technique", dated 11/30/14 and provided by the Assistant Director of Nursing on			

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	9/24/15 at 11:30 a.m., indicated "...Personnel will wash hands to remove dirt, organic material, and transient microorganisms to prevent the spread of infection...Wet hands thoroughly. Take approximately 3-5 ml (milliliters) of soap from the dispenser...Thoroughly distribute soap over the entire area of hands and wrists...Rub hands together vigorously for 15-20 seconds, generating friction on all surfaces of the hands and fingers...." A current facility policy "Linen Handling", dated 11/30/14 and provided by the Regional Director of Clinical Services on 9/23/15 at 2:00 p.m., indicated "...Clean linen is handled with clean hands...." 3.1-21(i)(1) 3.1-21(i)(2)			
F 0425 SS=E Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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			

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	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 interview and record review, the facility failed to ensure glucometer calibrations were performed for 4 of 4 diabetic residents reviewed in the facility who monitored their blood sugars with individual glucometers. (Resident #16, Resident #13, Resident #2, Resident #32) Findings include: On 9/23/15 at 10 a.m. LPN #9 was interviewed. She indicated the glucometer (machine used to obtain a blood sugar level) calibrations (method to ensure blood sugar results are accurate) were completed by the night shift and logged on a record, which was kept in the MAR (medication administration record). She indicated each resident had their own glucometer and these were kept in the resident's room. LPN #9 indicated	F 0425	1.Residents #16, 13, 2, and 32 were assessed without adverse reactions. Physician reviewed each residents glucose recordings and no additional orders were noted. 2.All residents requiring glucose monitoring were assessed by the licensed nurse and MD. No adverse reactions were noted, no new orders given. 3.Licensed nurses will be in-service on facility policy and manufacturers' instructions for calibrating of glucometer machines. Licensed nurses will calibrate each Glucometer according to the manufacturer's instructions. Calibration will be recorded on the Quality Control Record each time calibration is completed. 4.DCS or designee will audit all residents Glucose Quality Control Record weekly for 4 weeks, then monthly for 2 months, then quarterly times 2 for review by QA committee. QA will determine the need for corrective action and	10/25/2015

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	from the MAR on the East hall and the West hall, there were a total of 6 "Blood Glucose Monitoring System: Quality Control Records" forms. These were the only quality control records located in the MARS and all of them were dated September 2015. Four of these records were reviewed. Of the 4 records reviewed, the only date a quality control was performed, was on 9/12/15 for 3 of the residents (Resident #16, #13, #32). The other resident had documented one quality control performed on both 9/12/15 and also on 9/15/15 (Resident #2). On 9/24/15 at 10 a.m., the following resident records were reviewed with the following observed: Resident #16 had 1 documented glucometer calibration for September on 9/12/15. Reviewed of the resident's current physician orders for 9/2015, signed by the physician on 9/2/15 indicated a physician order dated 11/25/14 for "Accucheck (blood sugar check using a glucometer) before meals and hs (bedtime)." Resident #13 had 1 documented glucometer calibration for September 2015, which was performed on 9/12/15. Review of the resident's current physician		continued monitoring.	

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	orders for 9/2015, signed by the physician on 9/2/15, indicated a physician order with a date of 9/29/14 for "Blood sugar before meals and hs." Resident #2 had Quality control records which indicated he had a glucometer calibration performed on 9/12/15 and 9/15/15. Review of the resident's current physician orders for September 2015 and signed by the physician on 9/2/15 indicated an order dated 8/26/15 for Glucoscans before meals and every bedtime. Resident #32 had 1 documented glucometer calibration for 9/2015, which was dated 9/12/15. Review of the resident's clinical record, indicated a physician order dated 8/31/15 indicated resident was to have glucometer checks performed 4 times a day. On 9/23/15 at 9:25 a.m. the Regional Director of Clinical Services (RDCS) provided a current copy of the facility policy and procedure for "Quality control check-glucose monitoring", dated 11/30/14. The policy included, but was not limited to, the following: "To ensure Blood Glucose Meters provide an accurate measure of Blood Sugar, the facility will complete Control Check on the Glucose Meter per manufacturer's			

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	recommendations. The policy included, but was not limited to, the following: "...Document results on the blood glucose meter quality control record. Forward sheet to the Director of Clinical Services or designee..." On 9/24/15 at 2:08 p.m. the RDCS provided a copy of the manufacturers instructions for the (name of glucometer) the residents at the facility utilized. These instructions had a revision date of 8/2011 and included, but were not limited to, the following information: "...Perform a control solution test: before testing with the (name of glucometer) for the first time, when you open a new bottle of test strips...If test results appear to be abnormally high or low...If the test strip bottle has been left open or has been exposed to light..." On 9/25/15 at 8:40 a.m. the LPN #12 from medical records, was interviewed. She indicated she was unable to locate any additional forms which would have indicated the glucometers had been calibrated in 2015. On 9/25/15 at 9 a.m. the Administrator and the ADCS (Assistant Director of Clinical Services) were interviewed. They indicated there were a total of 50 test strips in the bottles of glucometer test			

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	strips. They indicated if a resident was ordered to have a total of 4 glucometer checks a day, in 12 days, another bottle of test strips would need to be opened. On 9/25/15 at 12:30 p.m. the RDCS was interviewed. She indicated the facility had identified the lack of glucometer testing as a concern, but was unable to provide documentation of the date this concern was identified. She thought the inservice, which related to glucometer calibration and testing, was provided on 9/12/15 due to the date on one of the completed "Accu-check Testing and Equipment" forms. She did provide "Accu-check Testing and Equipment" forms for 3 staff members at the facility. She indicated these were the only forms she was able to locate in regards to the Accu-check inservice. They included but were not limited to, the following: (name of glucometer) manufacturer guidelines require that a control test be completed on the machine: "a. before testing with the system for the first time, b. when you open a new bottle of test strips, c. if the test results appear to be abnormally high or low or do not seem consistent with the resident's clinical symptoms, d. the test strip bottle has been opened or has been exposed to light, temperatures below..." The RDCS indicated all of the nursing staff would be required to complete these			

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	glucometer competencies, both the facility employed staff and also the agency staff that are utilized by the facility. She indicated she was unable to locate an employee sign in roster and/or additional written test for the Accu-check inservice. 3.1-25(a)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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			

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	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, interview, and record review, the facility failed to ensure infection control practices were followed for two residents to prevent the spread of infection (Resident # 61, Resident #16). The facility further failed to ensure nursing staff with a fever or symptoms of infection did not work with residents , and failed to protect clean linen from potential contamination potentially affecting all 28 residents in the facility. Findings include: 1. On 9/22/15 at 4:45 p.m. LPN # 9 was observed to prepare medications to pass to Resident #61. There was a sign on the door which indicated "See a nurse	F 0441	1.Resident # 61 no longer requires isolation precautions. Resident #16 was assessed without adverse outcome. 2.All residents have the potential to be affected. No other residents require isolation precautions. 3.All staff will be in-serviced on policy and procedures of infection control and prevention, and hand washing. 4.DCS or designee will conduct 5 employee observations per week of hand washing, until all employees until all employees have demonstrated proper hand washing correctly. Results of observations will be reported to QA for review. DCS or designee will conduct infection control audits weekly for 4 weeks, then 2 times monthly x 2, then monthly x 2,then quarterly. QA will review audits monthly and determine the need for corrective action and/or	10/25/2015

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	before entering." Resident #61 also had a bin with several drawers in it located in the hall, just outside of his room. LPN #9 was observed to walk into the resident's room without mask, gown, or gloves on. She put the medication cup down on the resident's bedside table and stood at the bedside until the resident took his medication. She then left the room and without sanitizing or washing her hands pushed the medication cart down the hall. At 4:47 p.m. LPN #9 was interviewed. She indicated Resident #61 had been in contact isolation precautions. She indicated Resident #61's physician had just given an order to obtain a culture to see if the infection was resolved. She indicated she wasn't sure whether the resident's MRSA (Methicillin Resistant Staphylococcus Aureus) infection was in the nares or urine. On 9/22/15 at 4:47 p.m. LPN #9 was observed to open the medication cart and begin to prepare medications for Resident #16. LPN #9 had not yet washed or sanitized her hands. She popped a pill from the bubble pack of pills and then poured a liquid medication in a medication cup.		continued monitoring.	

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	She was not observed to touch either medication with her hands. LPN #9 indicated she did not wash her hands after coming out of the isolation room of Resident #61. She continued to prepare medications for Resident #16. At this time, she was requested to wash her hands. She then put gloves on and took Resident #16's medication into his room without washing her hands. On 9/23/15 at 9:25 a.m. the RDCS (Regional Director of Clinical Services) provided a current copy of the facility policy and procedure for "Handwashing Technique." This policy had a revision date of 6/1/15 and included, but was not limited to, the following: "Personnel will wash hands to remove dirt...and transient microorganisms to prevent the spread of infection..." On 9/25/15 at 8 a.m., the clinical record of Resident 61 was reviewed. Diagnosis included, but were not limited to the following: History of traumatic brain injury. A history and physical from the (name of rehabilitation hospital) indicated the resident was admitted to that hospital on 9/4/15 and a			

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	diagnosis which included, but was not limited to, "Methicillin Resistant Staphylococcus Aureus positivity." The facility admission data collection form included, but was not limited to, the following: Resident had been admitted to the facility on 9/16/15. The admission nurses notes included, but were not limited to, the following: "Resident on isolation r/t (related to) hx (history) MRSA (Methicillin resistant staphylococcus Aureus) in sputum." The admission care plan included, but was not limited to, the following: "Infection Alert" was left entirely blank. The admission care plan included but was not limited to the following information: "Goal: to resolve infections: type: monitor for s/s (signs and symptoms) infection...infection control per protocol, isolation." A physician order, dated 9/17/15 included but was not limited to, the following: "isolation precautions, sputum culture to rule out MRSA." On 9/25/15 at 9:05 a.m. the Administrator and the ADCS (Assistant Director of Clinical Services) were interviewed. They indicate when Resident #61 was admitted to the facility 9/16/15			

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	from a hospital, he had a history of MRSA. They indicated MRSA precautions had been observed on the resident since his admission. On 9/25/15 at 9:10 a.m. the Administrator (ADM) and Assistant Director of Clinical Services (ADCS) were interviewed. They indicated the following: When the staff entered the room of Resident 61, they should have worn masks and gloves. They also indicated LPN #9 should have washed her hands prior to exiting the isolation room of Resident #61. They also indicated staff hands should be washed between passing medications to residents. They indicated Resident #61 had not had a temperature since he had been admitted to the facility. They indicated they had obtained a sputum specimen on 9/24/15. They indicated the facility had difficulty obtaining a sputum specimen from the resident and the resident had a nebulizer treatment in order to facilitate obtaining the sputum specimen. 2. An observation of the hall meal tray pass on 9-17-2015 at 12:03 p.m., indicated CNA #8 carried a meal tray into a room with a resident on isolation without donning any of the personal protective equipment			

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	prior to entering the room. An interview with LPN #7 on 9-24-2015 at 12:09 p.m., indicated "...she didn't know what someone had given her but she was running a fever on and off...." LPN #7 indicated she was "...probably giving it to people here...." An interview with the Administrator, ADON (Assistant Director of Nursing) and the Regional Director of Clinical Service on 9-25-2015 at 9:23 a.m., indicated staff with signs and symptoms of a fever were not allowed to work until they were 24 hours free from a fever. They were not aware of any staff working in the facility and who had a fever on 9-24-2015. An interview with the Administrator on 9-25-2015 at 10:47 a.m., indicated she could not locate a facility policy which listed the signs and symptoms in which employees who were ill were not to work. She indicated they follow a CDC (Center for Disease Control) guideline that indicated to "...stay home 24 hours at least after fever is gone...." 3. During an observation of the West Hall on 9/21/15 at 9:55 p.m., Certified Nursing Assistant (CNA) #6 was observed to carry a stack of clean towels			

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	through the hallway with her right hand underneath supporting the stack. She was observed to sneeze into her left hand and place her left hand on the top of the stack of clean towels. The Assistant Director of Nursing was interviewed on 9/24/15 at 11:40 a.m. During the interview she indicated staff were to carry clean linen away from their bodies. She also indicated clean linens were to be protected from contamination. A current facility policy "Linen Handling", dated 11/30/14 and provided by the Regional Director of Clinical Services on 9/23/15 at 2:00 p.m., indicated "...Clean linen is handled with clean hands...." 4. During an observation of the South Hall on 9/25/15 at 9:00 a.m., a Certified Occupational Therapy Assistant was observed to enter the room of Resident #61 wearing a disposable gown, disposable gloves, and a disposable mask as a precaution for MRSA. A few minutes later she was observed to leave the room of Resident #61 still wearing the same disposable gown, disposable gloves, and disposable mask. She proceeded the remove the disposable gown, disposable gloves, and disposable mask in the hallway outside of the			

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	resident's room. On 9/25/15 at 9:10 a.m. the ADCS provided a current copy of the facility policy and procedure, with a revision date of 7/8/15, for "Preventing Spread of Methicillin Resistant Staphylococcus Aureas (MRSA)..." The policy included, but was not limited to, the following: "...Policy: Residents who are infected or colonized with MRSA..." The procedure included, but was not limited to, the following: "Wear clean, non-sterile gloves when caring the MRSA infected (person has signs of an infection, fever, drainage, etc) or colonized (a resident has the bacteria present on the skin or body openings but has no signs of infection) resident...Clean, non-sterile gowns shall be worn when caring for the infected or colonized resident if you anticipate contact with the resident, environmental surfaces, items in the room, etc. Gloves and gown shall be removed before leaving the resident's room and placed in a plastic bag. Wash hands immediately with an antimicrobial soap... Continue precautions until the infected resident completes antimicrobial therapy and is asymptomatic and/or is culture-negative twice...." 3.1-18(k) 3.1-18(l)			

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	3.1-19(g)(2)			
F 0465 SS=F Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the building was maintained in a clean and homelike manner for for 2 of 3 halls observed (West and East Hall) for Room #109, #108, #107, #106, #112, #104, West Hall shower room, #101,#140, #139 and #132. The facility further failed to ensure the ice machine in the South Hall, which was used to serve residents ice, was maintained in a clean manner. This deficiency had the potential to affect 28 of 28 residents who resided in the facility. Findings include: 1. On 9/24/15 at 10 a.m. the following observations were made in the following rooms: Room 109: The bedside table was missing 1 of the 2 knobs on the front of	F 0465	1.Repairs will be made to rooms 109, 108, 107,106, 112, 104, 101, 140, 139, 132 and the West Hall Shower rooms. Areas noted to resident rooms and bathrooms were cleaned, missing knobs to furnishings replaced, resident drawers were adjusted and furnishings repaired and/or removed until replaced. Resident and responsible parties will be notified of repairs needed. 2.All resident rooms, shower rooms, and care areas were assessed for repairs. A repair schedule/renovation plan will be in place to address repairs needed. Resident and responsible parties will be notified of repair schedule and plan to address areas. 3.Maintenance Director will be re-educated on preventative maintenance schedule. Maintenance director will perform a preventative maintenance scheduleaccording to facility policy. Staff will record maintenance issues on facility work order report daily.	10/25/2015

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	the drawer; the ceiling vent, observed in the center of the room had 2 of the 4 screws missing from the frame of the vent and one side of the vent frame was hanging down 1/2 inch from the ceiling. Only 1 side of the louvered vent was flush with the ceiling. Room 108: The ceiling vent in the center of the room had 2 of 4 screws missing from the vent frame and had a 1 inch gap between the edge of the vent frame and the ceiling. The horizontal blinds which were closed, had several blind louvers which were bent and sticking out in places. There was an area over the TV in the room of tan paint, 1 foot by 1/2 foot, in contrast to the white painted ceiling. Room 107: The ceiling vent had louvers dislodged and bent. Room 106: The bedside cabinet had veneer missing with the particle board exposed along the entire vertical edge of the cabinet. The veneer to the side of the cabinet, which was visible from the door, was loose, torn, and the particle board beneath was visible. The ceiling vent in the center of the room was observed to have the edge of the vent frame hang down 1 inch from the ceiling on 2 sides of the vent. 2 of the 4 screws were missing from the vent frame. There was		Maintenance Director or designee will conduct daily rounds to ensure is in safe, comfortable environment. Repairs or supplies needed or unavailable will be reported to the Administrator and/or Regional Maintenance Director for servicing. Rounds will continue by ongoing as a quality assurance measure. 4.Results of rounds and work orders will be reported to QA monthly for 6 months. QA will determine corrective action. Renovation plan will be reviewed monthly by QA until completion.	

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	also the white paint, dry wall material missing from all sides of the ceiling which surrounded the vent, exposing brown material beneath. This room shared a bathroom with resident Room 105. The counter of this shared bathroom was observed to have dark stains on the counter top around 1/4 of the round sink. There was old, dried, yellow/orange adhesive type material on the wall just beside the resident's mirror. Room 112: Inside the resident's room, on a wall visible from the resident's bed, was an area 1 1/2 feet up from the floor and 1 ft long, which was gashed and exposed the rough, irregular drywall beneath. Room 104: The horizontal blinds over the window were bent at both ends of the windows. The heads of both resident's beds in the room were against the same wall. The wall was painted a rust color and the ceiling was white. Along the top and right edge of the rust colored wall, were roller marks of a blue colored paint. On the wall where the window was located, there was a splatter pattern of a dried dark substance. The same dark substance splatter pattern was observed on the pastel plaid valance. The bottom drawer of the bedside cabinet for the bed by the window, was at an angle and did not close.			

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	West Hall shower room: the wall cabinet, which had been fastened to the wall, beside the showers, was gone. Room 101: This room was unoccupied at the time but had a knob missing to the closet door. The ceiling vent, also over the traffic pattern of the room was observed to have pieces of cardboard placed in the louvers of the ceiling vent. The cardboard pieces covered 1/2 of the louvers of the ceiling vents. Room 140: 2 of the 4 walls were painted a dark tan color and other areas in the room were observed to have random paint pattern along the edges of the walls in a contrasting color. Room 139: The horizontal blinds were bent and sticking out in areas. The ceiling vent also had a 1 and1/2 inch gap were it hung down from the ceiling. There was a brownish material in a square pattern on the white ceiling were it appeared another vent had been removed. This resident room shared a bathroom with room 140. When the bathroom door, to room 139 was closed (which was visible from inside the bathroom) there were unpainted, white spackling splotches on the interior of the door.			

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	Room 132: had a ceiling vent which was hanging down 1/2 inch from the ceiling. There was an edge of drywall 1 and 1/2 inches wide which was exposed around the edge where the vent would be if it was flush against the ceiling. On 9/24/15 at 2:35 p.m., the Maintenance Supervisor and the Administrator toured several of the above rooms. At this time, they were interviewed. The Maintenance Supervisor indicated he was in the process of replacing the vents to the rooms. He indicated he was trying to replace 6 vents a month. He indicated it was an ongoing project to replace the blinds in the rooms as well. He indicated he was trying to replace the type of vent that was observed in Room 107 first and these do not have a way to adjust air flow. He indicated the frames stick down "like they don't fit." The Maintenance Supervisor indicated that even though only 2 screws are visible from the room, there were really 4 screws in place in the ceiling which secured the vents in place. He indicated the valances were going to be removed from the rooms. He indicated all the rooms would be repainted and he has already painted some of them and also "mudded" some of them. He indicated this was a work in progress.			

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	On 9/24/15 at 3:10 p.m., the Maintenance Supervisor was interviewed. He indicated he started painting the last week of January 2015. He indicated his goal was to complete 2 rooms a week and he rarely meets his goal. He indicated he was the only employee in the maintenance department. He indicated the reason some of the vents had cardboard in them was that these were central units and had no way to control the air flow from the vents and to aid in resident comfort, the cardboard had been placed in the vents. He indicated he tries to keep vents on hand and replacements were at a resident's request (due to a resident's voiced concerns about temperature of their rooms). He indicated he has been unable to get a room done all at once as he has tried to complete the tasks when the residents were out of their rooms. On 9/25/15 at 9:05 a.m., the Administrator provided a copy of the current facility policy and procedure for "Maintenance" dated 11/30/14. The policy included, but was not limited to, the following: "The facility's physical plant and equipment will be maintained through a program of preventative maintenance and prompt action to identify areas/items in need of repair.			

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	Procedure: The Director of Environmental Services will follow all policies regarding routine periodic maintenance....will perform daily rounds of the building to ensure the plant is...in proper physical condition. All employees will report physical plant areas...in need of repair or service to their supervisor..." 2. An observation of the ice machine in the South Hall closet on 9-17-2015 at 9:50 a.m., indicated the container hanging on the wall where the ice scoop was stored was not clean on the bottom. Dirt debris was observed on the floor as well as stains along the edges of the individual tiles. A spider web was observed in the back right corner of the room and a spider web was observed on the baseboard to the right of the ice machine with a spider in the web. Inside the ice machine, there was a metal shield toward the back unit. An observation indicated there was water dripping from this metal shield into the ice bin which was full of ice. A paper towel was used to wipe the upper left area of the metal shield and the bottom edge of the shield which resulted in some rust colored and black debris which came off onto the paper towel. An observation of the ice machine room in the South Hall on 9-18-2015 at 8:35 a.m., indicated the floor in front of the ice			

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	machine was somewhat cleaner than the 9-17-2015 observation. However, the flooring to the right of the ice machine still had the spider web with the spider present along the baseboard and the floor was not clean. Inside the ice bin, the metal shield still had the rusty residue in the upper left corner and black residue on the bottom edge of the shield which came off on a paper towel when wiped with the paper toweling. The ice level was up to the bottom of the metal shield and water drips were observed on the shield that ran down into the ice storage bin. The ice scoop bin appeared to have been cleaned as the bottom of it did not have debris inside. An observation of the ice machine room in the South Hall on 9-20-2015 at 10:00 a.m., indicated the baseboard to the right of the ice machine still had the spider web along with the spider still in the web and another spider web with a spider was observed in the back corner. Inside the ice machine, the metal shield still had the rust debris on the upper left corner and on the bottom edge a black debris which could be wiped off onto the paper toweling. There was water condensation on the metal shield that was observed to drip down into the filled area of ice. An observation of the ice machine in the			

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	South Hall on 9-23-2015 at 1:44 p.m., indicated the spider web remained on the baseboard with the spider still in the web and a spider web with a large, dark bug was observed in the back corner. Inside the ice machine, the metal shield which was above the full bin of ice, was still observed with a rust debris on the upper left corner that came off onto the paper toweling when rubbed and black debris which came off on paper toweling from the bottom edge of the shield that was just above the ice. An interview with the Maintenance Supervisor on 9-23-2015 at 4:33 p.m., indicated the ice machine in the south hall had a chemical run through it monthly to de-lime the machine, and quarterly the ice machine was cleaned inside and out. The Maintenance Supervisor indicated the last quarterly cleaning was in April 2015 and the quarterly cleaning was not completed in July 2015. The Maintenance person was shown the areas of concern on the ice metal shield of the rust color area on the upper left side and the bottom edge of the metal shield with the black debris. The Maintenance Supervisor indicated the water does run down the metal shield into the ice bin. The Maintenance Supervisor indicated he did not know who was responsible to ensure the room in which			

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	the ice machine was used was cleaned. An observation on 9-24-2015 at 8:45 a.m., indicated the housekeeping staff used a dust mop to clean the vent in the ceiling in the ice machine room in the South Hall. An interview with the Housekeeping Manager on 9-24-2015 at 8:57 a.m., indicated the ice machine room was deep cleaned on a monthly basis and the housekeeping staff was responsible to clean the floor and dust the vent on a daily basis. An observation of the South Hall ice machine room with the Housekeeping Manager indicated the floor in front of the ice machine was wet and the cobwebs along the baseboard to the right of the ice machine were gone. There were cobwebs in the doorway corners, near the ceiling and 3/4 way up the wall to the right of the ice machine. Under the ice machine, the floor was not observed to be wet and stains were visible at the edges of the tile. An interview with the Housekeeping Manager on 9-24-2015 at 9:03 a.m., indicated she was unable to remove the floor stains under the ice machine. An interview with the Administrator, Assistant Director of Clinical Services			

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	and the Regional Director of Clinical Services on 9-24-2015 at 9:50 a.m., indicated they were not aware of the lack of cleanliness of the ice machine and the room in which the ice machine was stored. An interview with the Maintenance Supervisor on 9-24-2015 at 9:58 a.m., indicated the manufacturer's instructions were to completely clean the ice machine every 6 months and he indicated the facility is doing it quarterly. The Maintenance Supervisor was observed to open the ice machine in the South Hall and the metal shield was observed to be clean of the rust on the upper left side. The Maintenance Supervisor indicated he cleaned the metal shield. A current policy "Ice Machine & Scoops" dated 1-2009 and provided by the Administrator on 9-24-2015 at 10:22 a.m., indicated the "...ice machine will be cleaned and sanitized biannually...ice scoops will be cleaned and sanitized daily...." 3.1-19(f)			
F 0520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET			

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Bldg. 00	QUARTERLY/PLANS 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 observation, interview and record review, the facility's Performance Improvement (PI) Committee failed to identify and implement action plans for the following identified concerns regarding ensuring adequate ADL's (Activity of Daily Living) were provided as scheduled; ensuring the medication error rate was less than 5% (percent); ensuring glucometers were calibrated appropriately and timely, and ensuring adequate nursing staff were available to provide care and services for the residents. The facility PI Committee	F 0520	1.Action plans for ADL care, Infection Control, Sanitation, Medication Errors, Glucometer Control, Staffing and Physical Plant wereimplemented by the QA committee. QA committee includes the Administrator, Director of Clinical Services, Medical Director, and department directors 2.All residents have the potential to be affected. QA will review action plans, evaluate, analyze, and revise accordingly to ensure positive resident outcomes are achieved regarding resident care and facility	10/25/2015

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	failed to ensure the kitchen was maintained in a clean and sanitary manner, ensure food was not contaminated, and ensure adequate handwashing during meal service. The facility PI Committee further failed to ensure infection control was maintained in an isolation room by nursing staff including wearing appropriate PPE (Personal Protective Equipment), ensure adequate handwashing at appropriate times in an isolation room and during medication administration, ensuring linens were protected from contamination; ensuring the ice machine used for resident's ice was maintained in a clean and sanitary manner; and ensuring the residents' rooms were clean, safe and homelike. This had the potential to affect 28 of 28 residents who reside at the facility. Findings include. An interview with the Administrator and the Assistant Director of Clinical Services (ADCS) on 9/25/15 at 11:20 a.m., indicated the PI Committee met monthly. The Administrator and the ADCS indicated they had only been at the facility for 2 to 3 weeks. The Administrator indicated the committee usually meets the third Wednesday of each month but indicated the Committee		practices. 3.Regional nurse consultants will in-service QA committee on policies and procedures and/or clinical systems to ensure action plans areeffective. 4.QA committee will review action plans and audits provided by departments monthly and determine if corrective action, such as modification of action plan, additional training, etc. is needed. Monthly review of QA plans is an ongoing measure for quality assurance.	

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	had not met since State Survey team was in the facility. She also indicated she had reviewed the prior PI Committee minutes. The Administrator indicated the committee consisted of the Administrator, the Medical Director, the DCS (Director of Clinical Services), Social Services and Medical Records and Department Managers. She also indicated not every Department Manager attends the PI meetings monthly and only attended if their department was involved with a current concern or monitoring. She also indicated the Pharmacy Consultant and Therapy Department Manager attend as needed. She indicated the PI committee reviewed incidents and falls monthly. She also indicated adequate staffing had been identified recently with a complaint and were working on a plan of correction to maintain an adequate nursing staff. She also indicated an action plan was tried and failed for dining services and changes were made to the action plan. The Administrator indicated the committee would be developing an action plan for the kitchen and indicated it would take a lot of planning to coordinate the needed kitchen repairs. She indicated handwashing, isolation precautions and proper handling of linens were followed by and were part of infection control. She indicated the PI Committee reviewed			

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	the number of infections, the source and trending of infections monthly but not handwashing, isolation precautions or linen handling. The Administrator indicated the facility had a process for auditing Physician's orders but indicated some were missed and they would need to re-evaluate the process to make sure all physician orders would be followed. The Administrator indicated the charge nurse was responsible to make sure all ADL's, including showers were completed as scheduled and all resident's would need to be interviewed on their preferences and assistance needed and a scheduled developed. She indicated the PI Committee reviewed medication errors monthly and would need to discuss an action plan with the Medical Director for the medication errors and insulin administration. She also indicated she had not been aware the Glucometers were not calibrated routinely. She indicated the MDS (Minimum Data Set Assessment) Coordinator oversees the collection of resident's assessment information, but each facility department was responsible to provide accurate and complete information for the assessments and to develop the appropriate care plans for each resident. She indicated they were aware of the needed updates and repairs in the residents' rooms and indicated it was a slow process. The			

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	Administrator indicated some renovations had occurred since the beginning of the year and indicated the ice maker would be cleaned and maintained. The Administrator further indicated all of the concerns would be reviewed by the PI Committee and action plans would be developed and monitored monthly. On 9/25/15 at 11:10 a.m., the Administrator provided the current facility's policy, Performance Improvement Committee (Quality Assurance), effective date: 11/30/14, which indicated, "...The Performance Improvement Committee will meet monthly to review, recommend and act upon activities of the facility, performance action teams and/or departmental activities. The committee shall direct all activities including approving proposed monitoring, evaluating and review of services...The committee will assure QAPI (Quality Assurance Performance Improvement) activities have written indicators and standards/thresholds for evaluation, that appropriate actions are implemented, and that such correction has been evaluated by subsequent monitoring...The Performance Improvement Committee will develop and revise the Performance Improvement Calendar annually and as			

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	needed to ensure the Performance Improvement Program review and addresses key aspects of care and key indicators using date from multiple sources that evaluate a full range of care and services. This includes but is not limited to the company Performance Indicators....The Committee will assign interdisciplinary performance action teams activities and monitor the team's progress. A Performance Action Team will be developed to collect and evaluate data and to plan and implement needed action under the direction of the Performance Improvement Committee...." 3.1-52(a)(2)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquires shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in the accordance with IC 16-28-13-3.	F 9999	1.Prior employment dates were verified for the Maintenance Director. General orientation and job specific orientation was reviewed and signed by the Maintenance Director. 6 hour Dementia Training will be completed by the Maintenance Director. A job description was reviewed and signed by the Administrator. Physical exams were completed on LPN #9, CNA #10, DCS, Maintenance Director,	10/25/2015

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	(p) Initial orientation of all staff must be conducted and documented and shall include the following: (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (q) Each facility shall maintain current and accurate personnel records for all employees. The personal records for all employees shall include the following: (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test. (1) At the time of employment, or within 1 month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin		and Administrator. Annual TB test will be provided to Cook #11. DCS and CNA #10 will receive 2 steps testing for TB. 2.All employees' files will be reviewed to ensure references, TB screens, health exams, and completion of orientation and job specific orientation, including signed job descriptions are on file for each employee. 3.All staff will receive annual dementia training. The Human Resource Coordinator will be in-serviced on Policy and Procedures for Pre-Employment Verification and requirements, including orientation program for all employees. Human Resource Coordinator will audit all new employee files to ensure necessary documents are in each employee file. A pre-employment checklist will be used priorto employees first day of work. An employee file checklist will be used to ensure required documentation is in place. HR coordinator will audit new employee files within 14 days of hire to ensure employees received job specific orientation and training, in addition to ensuring all other documents are in place in each employee file. Issues identified will be corrected by the department supervisor. 4.HR coordinator or designee will audit all newly hired employee files monthly. Results of audits will be reviewed in QA monthly times 3 months, and then	

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	155359	A. BUILDING 00 B. WING	09/25/2015

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	testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; (B) reports of all employment-related health examinations. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This RULE: is not met as evidenced by: A. Based on record review and interview		quarterly times 3. QA will determine the need for corrective action and/or continued monitoring.	

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	the facility failed to ensure specific inquires of the employee's references for 1 of 5 newly hired staff.(Maintenance Director) B. Based on record review and interview, the facility failed to ensure 1 of 5 newly hired staff received and reviewed their job description required for the specific position to which they were hired. (Administrator) C. Based on record review and interview the facility failed to ensure 1 of 5 newly hired staff received general and specific orientation to the facility and their specific position. (Maintenance Director) D. Based on record review and interview, the facility failed to ensure 5 of 5 newly hired staff received a health screening prior to the start of employment. [DCS (Director of Clinical Services), the Maintenance Director, LPN (Licensed Practical Nurse) #9, CNA (Certified Nursing Assistant) #10, and the Administrator]. Furthermore, the facility failed to provide 2 step testing for tuberculosis (TB) for 2 of 5 newly hired staff. (DCS and CNA #10). The facility also failed to complete annual TB skin testing on 1 of 5 employees who required annual TB testing. (Cook #11).			

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	E. Based on record review and interview the facility failed to ensure 6 hours of dementia training was completed with in 6 months from start of employment for 1 of 10 staff reviewed for dementia training. (Maintenance Director) Findings include: A.1. Five newly hired employee files were reviewed on 9/24/15 at 2:00 p.m. The employee file of the Maintenance Director did not contain evidence the references, which were provided by the Maintenance Director, were contacted and reviewed. Human Resources was interviewed on 9/24/15 at 3:30 p.m., During the interview she indicated the information on references checks were not in the personnel file. B.1. Five newly hired employee files were reviewed on 9/24/15 at 2:00 p.m.. The employee file for the Administrator did not contain a signed job description. Human Resources was interviewed on 9/24/15 at 3:30 p.m.. During the interview she indicated the Administrator's job description was not in her employee file.			

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	The Administrator was interviewed on 9/25/15 at 10:10 a.m.. During the interview she indicated she had not received a job description to review and sign. She indicated she received an offer letter for the position. C.1. Five newly hired employee files were reviewed on 9/24/15 at 2:00 p.m. The employee file for the Maintenance Director did not contain evidence he was oriented to the facility policies and procedures or the specific required orientation to his position as the Maintenance Director. Human Resources was interviewed on 9/24/15 at 3:30 p.m.. During the interview she indicated the orientation documents were not in his employee file. D.1. Five newly hired employee health files were reviewed on 9/24/15 at 2:00 p.m. and indicated the following: The employee files for the DCS, the Maintenance Director, LPN #9, CNA #10, and the Administrator did not contain a physical exam. The TB Screening Records for the DCS indicated the 1st (first) step Mantoux Method (TB testing) was done on 12/22/14 with results of 0(zero) mm			

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	(millimeter) [a negative TB skin test]. The next documented TB skin test was done on 6/9/15 with result of 0 mm. Another TB skin test was done on 6/17/15 the results indicated 0 mm. The TB Screening Record was not in CNA #10's employee file. The TB Screening Record for Cook #11 indicated her last Mantoux test for TB was done on 7/14/14. Human Resources was interviewed on 9/24/15 at 3:30 p.m.. During the interview she indicated the she would have provided the employees' physical exams if they were in their files and further indicated the physical exams probably were not done. She indicated she had provided the current TB testing records available in the employee files. Human Resources was interviewed on 9/25/15 at 10:05 a.m.. During the interview she indicated she had not looked again for the newly hired employees' physical exams and the missing TB testing. She indicated she would re-check the files for the missing documents and would also check if the DCS provided proof of prior TB testing with in the past 12 months. She indicated she would provide the documents if she			

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	found them. The Administrator was interviewed on 9/25/15 at 10:10 a.m.. During the interview she indicated she did not have a physical exam within one month of beginning work at the facility. The current facility policy, titled, Post-offer/Pre-Employment Physical Examination and Health Screening, dated 11/30/14, was provided by the Administrator on 9/25/15 at 10:44 a.m.. The policy indicated, "...it is the policy of The Company, that in applicable states, all new facility employees must receive a post-offer, pre-employment physical examination, conducted by a licensed physician or approved designee if state law mandates. All newly hired employee must complete a pre-placement health screening....The hiring manager must inform new employee that offers of employment are contingent upon successful completion of the pre-placement health physical examination. This will include , at minimum...a statement that the employee is free from communicable diseases and TB screening for these employees involved in resident care...Qualified candidates must meet the physical demands of the job in order to successfully perform the essential			

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	functions of the job applied for....Pre-employment physical examination reports...must be maintained in a medical file...." E.1. The employee file for the Maintenance Director indicated he was hired on 1/14/15. The file did not contain documentation indicating he had completed the required 6 hours Dementia training within the first 6 months of employment. Human Resources was interviewed on 9/24/15 at 3:30 p.m.. During the interview she indicated the documentation for dementia training was not in his file. The facility did not provide additional documention for the missing employee file requirements. The facility also did not provide additional facility policies for the required documents to be maintained in the employees' files, or the facility's employee's handbook at time of exit on 9/25/15 at 1:15 p.m.			