STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 00 B. WING	06/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 1, 2, 3, 4, 5, 8, and 9, 2015 Facility number: 002982 Provider number: 155700 AIM number: 200382090 Census bed type: SNF: 11 SNF/NF: 63 Total: 74 Census payor type: Medicare:14 Medicaid: 23 Other: 37 Total: 74 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Please accept this Plan of Correction as ourcredible allegation of compliance. Submission of this Plan of Correction does notconstitute admission of the allegations contained in the CMS 2567 for thissurvey letter dated 6-16-2015.	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and			

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

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

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	services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interviews, the facility failed to ensure interventions were provided to prevent a decline in bowel continence for 1 of 3 residents reviewed for incontinence. (Resident #43) Finding includes: The clinical record for Resident #43 was reviewed on 6/03/2015 at 2:48 P.M. Resident #43 was admitted to the facility on 10/15/14 with diagnoses including, but not limited to, lewy body dementia, hypertension, seizures, tremors, depression, failure to thrive, pacemaker, prostate cancer, congestive heart failure transischemic accidents, ulcerative colitis, weakness, and dehydration. The initial MDS (Minimum Data Set) assessment for Resident #43, completed on 10/22/14, indicated he was occasionally incontinent of bowel. An MDS assessment, completed on 04/27/15 due to a significant change in the resident's status indicated Resident #43 had declined and was now frequently incontinent of bowel.	F 0309	F 309 **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?** Resident#43 has been reassessed for bowel continence to determine interventions thatwill be provided and care planned. **Howwill other residents having the potential to be affected by the same deficientpractice be identified and what corrective action will be taken?** All current MDSs willbe reviewed for indicators in decline of bowel continence. All residentsidentified will be reassessed to determine if interventions are needed and willbe care planned as necessary. **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur?**Facility hasreviewed Bowel Assessment and Retraining Policy with procedures revised andupdated. An in-service will be presentedto inform nursing staff of changes to the Policy and Procedure prior toimplementation. **Howwill the corrective action be monitored to ensure the**	07/09/2015

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	A review of the nurses notes and fall incident reports from January 2015, through June 4, 2015, indicated Resident #43 had fallen 9 times. The investigative reports indicated 7 of the 9 falls the resident had was when the resident was attempting to toilet himself. The Bowel and Bladder Evaluation Grid assessment form completed on 10/15/14 indicated, Resident #43 was incontinent of his bowel 4 or 5 times weekly, needed assistance to ambulate, was confused and needed physical prompting, and was sometimes aware of the need to void. It was unclear if the awareness of the need to void was for bladder, bowel, or both. During an interview, on 6/4/15 at 2:45 P.M., RN #5 indicated Resident #43's attempts to toilet himself were almost always related to his need to have a bowel movement. A care plan for Resident #43, dated 5/21/15, indicated there was a plan to address the resident's inflammatory bowel disease: ulcerative colitis with interventions to update the physician as needed and administer medications as ordered. There was also a plan, dated 11/19/14, to address the resident's risk for constipation due to immobility. The interventions did not indicate any		**deficient practice willnot recur, i.e. what QA program will be put into place?** Director of Nursing/designee will reviewMDS schedule weekly to identify decline and ensure initiation of bowelassessment and retraining. This will beaudited weekly for 2 months, then bi-weekly for 2 months, then monthly for 2months. The DON/designee will presentthe results of the audits to the QA Committee monthly for further review andany recommendations. **By what date will the systemicchanges be completed?**By July 9, 2015.	

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	toileting routine except to position him upright on a toilet or bedside commode. The care plan related to falls indicated the resident was to be offered toileting on rounds on all shifts. During an interview, on 6/4/15 at 2:45 P.M., RN #5 indicated "rounds" were conducted approximately every two hours. The Bowel Assessment policy, provided by the Director of Nursing on 06/05/15 at 9:00 A.M. indicated a bowel assessment was to be completed 7 days after a resident was admitted to the facility. The procedure for completing the Bowel assessment indicated the clinical coordinator was to schedule a bowel assessment, the charge nurse was to inform the nursing staff of the beginning and ending dates of the assessment period. The assessment period was to "continue for 2 weeks." The bowel elimination record was to be noted and reviewed to determine if there was a pattern and the if the resident was deemed a candidate for a bowel retraining program, it was to be initiated. There were no instructions or policy to indicate when the bowel continence needed to be reassessed. A two week elimination record had not been			

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	completed on admission or with any declines in his bowel continence. 3.1-37(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, interview and record review, the facility failed to ensure there were clinical indications for the use of an indwelling Foley catheter and lack of initiating bladder retraining for 2 of 2 residents. (Resident #17 & Resident #107) In addition the facility failed to ensure a decline in bladder contingency had interventions to restore as much normal bladder function as possible for 1 of 1 residents reviewed for incontinence decline. (Resident #3)	F 0315	F 315 **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?** Resident#107 has been reassessed and currently under care of a Urologist who hasordered Foley catheter remain anchored with diagnosis of urinary obstructionsecondary to BPH. Resident #17 has beenreassessed by a Urologist on 6-16-2015 for continued need for placement of Foleycatheter	07/09/2015

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	Findings include: 1. During an interview with the Assistant Director of Nursing, on 06/02/15 at 10:22 A.M., she indicated Resident #107 had an indwelling urinary catheter related to urinary retention. On 6/4/15 at 9:45 A.M., the resident was observed to have a Foley catheter with a collection bag containing dark clear urine. The clinical record for Resident #107 was reviewed on 06/04/15 at 10:00 A.M. Resident #107 was admitted to the facility on 05/28/15 with diagnoses, including but not limited to, status post left femoral neck fracture, cardiomyopathy, chronic respiratory failure, chronic kidney disease - stage 3, diabetes mellitus, hypertension, dementia, history of falls, venous insufficiency, benign prostatic hypertrophy, history of colon cancer, hard of hearing, depression, and pain. The initial bowel and bladder evaluation assessment, completed on 05/29/15, indicated at the time of admission the resident had displayed urinary incontinence. The physician orders on admission, dated		due to diagnosis of BPH with obstruction resulting in chronic urinaryretention. The Care Plan has beenreviewed and updated. Resident #3 hasbeen reassessed for urinary incontinence to determine interventions that willbe provided and care planned. **Howwill other residents having the potential to be affected by the same deficientpractice be identified and what corrective action will be taken?** 1) A review of entirefacility was performed and no other residents have Foley catheters in place. Upon admission or significant change, abladder assessment on all residents will be completed quarterly according toMDS schedule. 2) All current MDSs willbe reviewed for indicators in decline of bladder continence. All resident identified will be reassessed todetermine if interventions are needed and will be care planned asnecessary. **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur?**1) Staff willbe in-serviced on clinical indicators, stage III or IV ulcers and use ofindwelling Foley catheters. 2) Facilityhas reviewed Bladder Assessment and Retraining Policy and Procedures have beenrevised and updated. An in-service willbe presented to inform nursing staff of changes to	

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	05/28/15, included an order for straight catheterization every shift for urinary retention. A nursing note, dated 05/28/15 at 11:00 P.M. indicated, the resident had been admitted to the facility. A subsequent nursing note indicated the resident voided 300 cc of urine at 11:51 P.M. A nursing note, dated 5/29/15 at 4:45 A.M., indicated the resident's brief was wet, he was able to void a small amount and he refused several times to allow a straight catheterization. A nursing note, dated 05/29/15 at 6:21 A.M. indicated the physician wanted I/O (intake and output) monitored for 72 hours. A nursing note dated, 05/29/15 at 3:00 P.M., indicated Resident #107 had been catheterized as ordered and 1000 ml of urine was returned. The resident's pull up (incontinence brief) was also wet. An email was sent to the physician requesting possibly anchoring a Foley catheter. A nursing note dated, 05/29/15 at 10:15 P.M., indicated the resident's brief was soaked, he was catheterized and no urine was returned. He also had no complaints		the policy and proceduresprior to implementation. **Howwill the corrective action be monitored to ensure the deficient practice willnot recur, i.e. what QA program will be put into place?** 1) DON/designee will audit all newadmissions with Foley catheters to ensure that clinical indications exist forcatheter use. Audit will be performed 5 outof 7 days per week for 6 months. Auditresults will be summarized and presented to the QA Committee monthly forfurther recommendations. 2) DON/designeewill review the MDS schedule weekly to identify decline and ensure initiationof bladder assessment and retraining. This will be audited weekly for 2 months, then bi-weekly for 2 months,then monthly for 2 months. Outcomes will be reported by DON/designee to the QAcommittee monthly for further recommendations. **By what date will the systemicchanges be completed?**By July 9, 2015.	

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	of pain or discomfort at the time. A nursing note, dated 05/30/15 at 3:30 A.M., indicated a physician's order, which had been received on 05/29/15 at 2:26 P.M., was noted regarding anchoring a Foley. A subsequent nursing note, dated 05/30/15 at 4:00 A.M. indicated a, indwelling Foley catheter was anchored and 1000 ml of urine was returned at the time. There was no indication the resident had been encouraged or had attempted to void prior to anchoring the catheter. The Intake and Output Record for Resident #107 for 05/29/15 indicated on the night shift the resident had voided x 1 (once). He had also been documented as voiding once on the evening shift, and on the day shift he voided once and had 1000 cc (cubic centimeters) per the Foley. On 05/30/15 there was no output documented. On 05/31/15 on the second shift 750 cc of urine was documented for his output. There was no further documentation regarding output for Resident #107 for May 2015. A physician's progress note from the acute care facility, dated 05/28/15 on the day the resident was discharged from the			

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	acute care facility, indicated the resident had a history of urinary retention, had required some straight catheterization due to a hydra scan of greater than 600 ml (milliliters) of urine retention. The facility's policy and procedure, titled Urinary Incontinence and Cathetrerzation, provided by the Director of Nursing on 06/05/15 at 11:00 A.M., indicated the following: "A resident will not be catheterized unless the resident's clinical condition demonstrates that catheterization is necessary....[facility name] will assess residents at risk for urinary catheterization and/or assess for any resident who currently has a catheter...2. A comprehensive assessment will address factors that predispose to develop urinary incontinence and for the use of an indwelling urinary catheter...." 2. On 6/8/15 at 12:43 P.M., a review of the clinical chart for Resident #17 was conducted. The record indicated the resident was admitted on 8/20/14. The resident's diagnoses included, but were not limited to, BPH (Benign Prostatic Hypertrophy), weakness, NIDDM (Non-Insulin Dependant Diabetes Mellitus) and renal failure. An admission Bowel and Bladder Evaluation Grid, dated 8/20/14, indicated			

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	the resident was a "fair" candidate for a re-training program. The form did not indicate the resident had a foley catheter. A Nursing Admission Assessment, dated 8/20/14, indicated the resident had a Foley catheter, and was not able to participate in bladder training. The explanation for no bladder training was "Foley catheter". A current Medication Administration Record (MAR) indicated, the resident was taking Flomax and Hytrin for BPH. The resident also received cranberry extract twice a day for UTI (Urinary Tract Infection) prevention. A Quarterly Minimum Data Set (MDS) assessment, dated 2/9/15 and 4/29/15, indicated the resident had an indwelling catheter, was not on a trial toileting program and his active diagnoses did not included a diagnosis in the genitourinary section. A urinalysis, dated 9/27/14, indicated the urine had 3+ bacteria,a small amount of blood, and 75-100 White Blood Cells (WBC), a culture indicated the urine contained enterobacter cloacae and pseudomonas species. Another urinalysis was completed on			

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	10/12/14. The Culture & Sensitivity (C&S) indicated the urine contained morganella morganii and enterococcus faecalis bacteria. A note of the culture results indicated the nurse called the office to report the results on 10/14/14 at 2:15 P.M. Another urinalysis completed on 2/13/15 with C&S completed on 2/18/15. The C&S indicated the urine contained Morganella Morganii and Enterococcus faecalis bacteria. A Nursing Note, dated 11/3/15 with no time, completed by the Infection Control Nurse, indicated the physician had been contacted and did not want to treat due to no symptoms of UTI. A Nursing Note, dated 2/12/15 at 9:10 P.M., indicated a new order for U/A, urine was collected on 2/13/15. On 2/15/15 at 1:15 P.M., the nursing note indicated the physician had no new orders because the resident had no symptoms of a UTI, continue to monitor. Nursing Note dated, 2/15/15 at 2:00 P.M., indicated the resident wanted to have the Foley catheter removed to "see how it goes" even though he had BPH. Resident verbalized understanding the catheter may be replaced if he had urinary			

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	retention. A Nursing Note, dated 2/16/15 at 6:00 A.M., indicated per physician's order the Foley catheter was removed. At 2:15 P.M. the resident voided one time on the day shift and urine output had been minimal. At 4:30 P.M. the resident complained he wanted the catheter inserted because he couldn't "get up and walk to the bathroom". The resident had voided once on the second shift. At 7:40 P.M. daughter called and complained about the catheter being removed and told nurse she wanted the catheter re-inserted and if not re-inserted she would be knocking on the physician's door. At 8:15 P.M. the physician contacted the nurse to have the Foley catheter re-inserted and 150 milliliters of urine was obtained with the insertion of the catheter. A care plan, dated 11/20/14, indicated the resident had an indwelling urinary catheter related to urinary retention and BPH. The goal indicated the resident would not exhibit signs of UTI or urethral trauma daily thru next review. The interventions included, but were not limited to, apply leg bag with extension tubing upon rising, apply UD (Urinary Drainage) bag when in bed at bedtime, assess drainage, odor & color, change			

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	catheter per MD (Medical Doctor) order, position below level of bladder, store collection bag inside a protective dignity pouch and report signs of UTI. During an observation, on 6/8/15 at 4:30 P.M., the resident had a leg bag catheter, positioned below the level of the bladder. During a telephone interview, on 6/8/15 at 4:45 P.M., the Infection Control Nurse indicated the resident had problems with UTI's that weren't resolving and he never had symptoms of a UTI. In February of this year another U/A was obtained and the Foley was removed, however the resident was unable to void and the Foley was inserted again. The physician consulted a infectious disease physician, and later ordered a renal ultrasound. The Infection Control Nurse had not seen a pattern of increased UTI's and had not done any training or education regarding UTI's nor catheter insertion/catheter care. On 6/8/15 at 9:00 A.M., the DON provided a policy titled "Urinary Incontinence-Catheterization" and indicated the policy was the one currently used by the facility. The policy indicated "...4. The assessment of continence/incontinence will be based upon an interdisciplinary review. The review will include underlying factors			

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	supporting the medical justification for the initiation and continuing need for catheter use, determination of factors which can be modified or reversed and the development of a plan for removal. 5. For the resident with an indwelling catheter, the facility will document their assessment and staff knowledge of the resident which will include information to support the use of the indwelling catheter...." 3. On 6/4/15 at 11:07 A.M., a review of the clinical chart for Resident #3 was conducted. The record indicated the resident was admitted on 12/16/14. The resident's diagnoses included, but were not limited to, urinary incontinence, left femur fracture, history of a stroke, depression, and edema. The Nursing Admission Assessment, dated 12/16/14, indicated the resident was frequently incontinent (daily) of bladder. A Bowel and Bladder Evaluation Grid dated 12/17/14 indicated the resident voided with urinary incontinence occurring less than once a day. The resident's score was 16 which indicated the resident was a good candidate for a bladder retraining program.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A 3 day Bladder Diary, dated 12/16/15 thru 12/18/14, indicated the resident was continent. A care plan, dated 2/12/15, indicated the resident was frequently incontinent of urine and had a history of recurrent Urinary Tract Infections (UTI). The interventions included, but were not limited to: assist with toileting as needed, if resident incontinent, provide peri care, monitor for UTI and encourage fluids. The Admission Minimum Data Set (MDS) Assessment,dated 12/23/15, indicated the resident was occasionally incontinent (less than 7 episodes of incontinence). The MDS Quarterly Assessment, dated 3/25/15, indicated the resident was frequently incontinent (7 or more episodes of incontinence but at least 1 episode of continent voiding) An Occupational Therapy (OT) Plan of Care, dated 12/17/14, indicated the resident was referred to OT by the physician secondary to decline in all ADL functions due to recent GLF (ground level fall) resulting in a left inter trochanteric hip fracture and underwent surgery. The medical conditions indicated the resident had a history of incontinence with functional deficit with Activities of Daily Living. The resident			

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	155700	A. BUILDING 00 B. WING	06/09/2015

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	required maximum assist with toileting and transfers. During an interview, on 6/4/15 at 2:35 P.M., the MDS Coordinator indicated the resident was admitted with history of incontinence, the 3 day bladder diary indicated the resident was continent, with 2 episodes of incontinence. The March look back period from March 19 thru March 25 indicated the resident had 10 periods of incontinence with 2 to 3 times of continent periods each shift. The MDS Coordination indicated during the look back period the resident had 7 or more periods of incontinence and therefore showed a decline on the look back period for her quarterly assessment done on 3/25/15. During an interview on 6/4/15 at 2:47 P.M., the Assist Director of Nursing (ADON) indicated the resident was admitted to the facility with stress incontinence. The resident was in therapy strength training for transfers to the toilet, however the resident was never in therapy for bladder retraining after her decline. During an interview, on 6/4/15 at 3:03 P.M., CNA #6 indicated the resident was assisted to the restroom. She further indicated the resident wore a brief and at			

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	times would be dry and other times the brief would be wet. The CNA indicated she recorded the periods of incontinence and continence on an ADL (Activities of Daily Living) grid. During an interview, on 6/4/15 at 3:25 P.M., the Director of Nursing (DON) indicated she would be made aware of any declines in a resident's continence, during the morning meetings. She further indicated she was unaware of the decline in the residents continence. On 6/4/15 at 4:45 P.M., the DON provided a policy titled"Bladder Assessment Policy", undated and indicated the policy was the one currently used by the facility. The policy indicated "A bladder assessment will be completed seven (7) days after admission and/or when a change in continence occurs...7. If the resident is deemed a candidate for bladder retraining, the bladder retraining program will be initiated...." 3.1-41(a)(1) 3.1-41(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free			

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	from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure adequate physician indications were obtained to support the denial for a dose reduction of a hypnotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #6) Finding includes: On 6/8/15 at 11:15 A.M., record review indicated Resident #6 was admitted to the facility on 1/14/14 with diagnoses, including but were not limited to "...depression, insomnia, hypertension, cardiomyopathy and congestive heart	F 0329	F 329 **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?** Physicianhas reviewed resident #6 and documented his reasoning for not attempting GDR. **Howwill other residents having the potential to be affected by the same deficientpractice be identified and what corrective action will be taken?** An audit of allresidents who receive hypnotics will be performed to determine if GDR has beenattempted timely and if proper documentation was	07/09/2015

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	failure...." The resident's medication regimen included the hypnotic medication, Ambien 5 mg (milligrams) 1 tablet to be given every night at bedtime for insomnia, ordered on 3/9/14. A form titled "Psychotropic Medication Review", dated 10/8/14, indicated "...GDR [gradual dose reduction] recommended for Ambien 2.5 mg...." A Social Service note, dated 11/14/14, indicated "...current psychotropic meds reviewed at behavior meeting, GDR of Ambien to be requested...." A form titled "Note To Attending Physician", dated 11/14/14, indicated "... [resident name] receives Ambien 5 mg at bedtime for insomnia [since 2/14]. She is due for a dose reduction. She was discussed in the behavior meeting. Recommend: 1. Trial reduction of Ambien to 2.5 mg at bedtime. Physician response: 3. No change at this time [please leave a clinical note] pt (patient) well controlled...." A Social Service Note, dated 1/1/15, indicated "...current meds include zolpidem (Ambien) for insomnia. PCP [primary care physician] declined recent		present for any that have notreceive GDR. GDR will be performed or documentation will be obtained for anydiscovered to be out of compliance. **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur?**A form has beendeveloped for the physician to determine if agree or disagree with the GDRrecommendation from pharmacy and/or ID team and to provide documented reasonfor denial of GDR. Residents receivinghypnotics will be reviewed at monthly Behavior Management meeting and the formwill be reviewed at that time for presence of the proper documentation. DON/designee will refer any delinquentdocumentation to the Medical Director to discuss with the following physicianand/or to complete the assessment with proper documentation upon the followingweekly visit. **Howwill the corrective action be monitored to ensure the deficient practice willnot recur, i.e. what QA program will be put into place?** Social Services designee will audit the chartsof residents who receive hypnotics monthly to verify proper documentation is inplace regarding decisions made in response to pharmacy and/or the BehaviorManagment	

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	GDR...." A form titled "Psychotropic Medication Review", dated 3/25/15, indicated "...recommend GDR of Ambien...." A Social Service Note, dated 4/10/15, indicated "...current meds reviewed at behavior meeting. GDR of Ambien to be recommended...." A form titled "Note To Attending Physician", dated 4/10/15, indicated "... [resident name] receives Ambien 5 mg at bedtime for insomnia [since 2/14]. She is due for a dose reduction. She was discussed in the behavior meeting. recommend: 1. Trial reduction of Ambien to 2.5 mg at bedtime. Physician response: 3. Physician circled no change at this time...." A Behavior/Intervention Monthly Flow Record, dated March, April, May and June 2015, indicated the targeted behavior was sleeplessness, the resident had no documented side effects and no documented behavior episodes in March, April, May, and June of 2015. During an interview, on 6/8/15 at 2:45 P.M., the Social Service Director indicated the resident had not had a GDR attempted for the Ambien since she had		Interdisciplinary team recommendations to GDR hypnotics. Results of the audits will be summarized andpresented to the QA Committee monthly for further recommendations. Audits willbe ongoing for 6 months and will expect to receive 95-100% compliance withinthe 6 months in order to eliminate ongoing completion of the audits. **By what date will the systemicchanges be completed?**By July 9, 2015.	

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	been on it. She further indicated the physician declined the attempted GDR in November 2014 and the reason was the patient was well controlled and in April 2015 the physician declined the attempted GDR and did not give a reason why. On 6/8/15 at 2:51 P.M., review of the current policy titled, "Psychoactive Drug Monitoring" received from the Social Service Director indicated, "...b. The continued need for the psychoactive medication is reassessed regularly by the prescriber and the care planning team. If continuation is deemed necessary, this is indicated in the medical record...Unless medically contraindicated, periodic dosage reductions are attempted and the results documented...h. For deviation from the recommended dosage and dosage reduction criteria, the clinical record contains evidence to support justification for use of a drug not meeting the dosage criteria but considered clinically appropriate by the physician. Examples include:...3. documentation that previous dosage reductions have been unsuccessful...." 3.1-48(a)(6)			

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F 0371 SS=E 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, record review, and interviews the facility failed to ensure food was handled in a sanitary manner during meal service and preparation in 1 of 1 kitchens. This deficient practice potentially affected 73 of 74 residents who consumed food. Findings include: 1. During an observation of the meal service, on 06/01/15 at 11:50 A.M., Cook #3 donned a pair of disposable gloves, touched a paper menu and handed it to another staff member, she then touched the handles of a large spoon and large spatula and dished food onto a dinner plate. She then, without changing her gloves reached onto a shelf and grabbed a dinner roll with her contaminated gloved hand and placed it onto the resident's dinner plate. 2. During an observation of the pureed food process, conducted on 06/03/15 at	F 0371	F 371 **What corrective action(s) will beaccomplished for those residents found to have been affected by the deficientpractice?** Foodwill be handled in a sanitary manner during meal services and during foodpreparation in the Kitchen of CKH. Cook #1 no longer works at CKH. **Howwill other residents having the potential to be affected by the same deficientpractice be identified and what corrective action will be taken?** All residents who eatfood prepared in the CKH kitchen have the potential to be affected by thedeficient practice. **Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur?**Cook #3 and AllDietary Staff have been re-educated by Certified Dietary Manager/designee onproper food handling including hand washing and proper glove use. **Howwill the corrective action**	07/09/2015

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	11:25 A.M., Cook #1 had washed her hands, measured out 4 servings of an already prepared turkey and gravy mixture, then after touching the outside of the pan of hot turkey and gravy, touched the outside of the robo coupe food processor, used her hand to open a drawer and obtained a spatula, then poured the mixture into the food processor and pureed the turkey and gravy. She then, handling the outside of the food processor and the spatula, pour the pureed food into a steam table pan. Then, she repeated the process, however, the blade from the food processor needed readjusted and she handled the blade with her hands and then pureed 8 more servings of pureed turkey and gravy. The facility policy and procedure, provided on 06/04/15 at 10:05 A.M. by the Assistant Director of Food Services, indicated "...2. hands must be washed prior to beginning work, after using the restroom, after smoking, when working with different food substance...Gloves 1. Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready to eat food. 2. When gloves are used, handwashing must occur per above procedure prior to putting on gloves and whenever gloves are changes. Gloves must be changed as often as hands need		**be monitored to ensure the deficient practice willnot recur, i.e. what QA program will be put into place?**Dietary Team Leader/designee will perform audit of tray service and of pureepreparation once per day, rotating meals observed, 7 days per week for 30 days. As long as 100% compliance is achieved for 7consecutive days, then audits will be reduced to one audit of 3 meals toinclude one Breakfast, one Noon meal and one Evening meal each week for 6months and as long as 100% compliance is maintained for 2 consecutive months,then may be discontinued or until the QA committee determines no longernecessary. Results will be documented onaudit tool and summarized by Dietary Manager/designee and presented to monthlyQA Committee for further recommendations. **By what date will the systemicchanges be completed?**By July 9, 2015.	

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	to be washed, see above. Gloves may be used for one task only...." 3.1-21(i)(2) 3.1-21(i)(3)			