

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155187	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: December 5, 6, 7, 8, and 9, 2016.</p> <p>Facility number: 000098 Provider number: 155187 AIM number: 100290980</p> <p>Census bed type: SNF/NF: 153 Total: 153</p> <p>Census payor type: Medicare: 17 Medicaid: 129 Other: 7 Total: 153</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 12/13/16.</p>	F 0000	<p>This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements</p> <p>The facility respectfully request paper compliance Thank you for your consideration,</p> <p>Respectfully, Jason Eastlund, BSW, HFA</p>	
F 0157 SS=D Bldg. 00	<p>483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>(g)(14) Notification of Changes.</p> <p>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-</p> <p>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p>			

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	<p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). Based on record review and interview, the facility failed to promptly notify the Physician related to a significant weight loss for 1 of 3 residents reviewed for nutrition. (Resident #29)</p> <p>Finding includes:</p> <p>The record for Resident #29 was reviewed on 12/7/16 at 12:43 p.m. Diagnoses included, but were not limited to, subdural hemorrhage, shortness of breath, anemia, heart failure, high blood pressure, and paranoid schizophrenia.</p> <p>The weight record was as follows: 8/14 130 pounds 8/24 127 pounds 9/12 130 pounds 9/19 131 pounds 10/18 129 pounds 11/3 122 pounds 11/9 125 pounds 11/17 124 pounds 11/22 121 pounds 11/28 118 pounds</p>	F 0157	<p>Nursing department notified MD prior to survey exit for resident 29. MD immediately ordered Megace for the patient.</p> <p>Clinical department reviewed all weight trends going back 30 days from 12.20.16, to ensure that physicians were appropriately notified and orders obtained.</p> <p>All licensed nursing staff were educated on the need to notify MD regarding significant weight loss/gain.</p> <p>All nursing notes, including weights, will be reviewed weekly for 6 months to ensure appropriate MD notification is occurring by clinical managers.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	01/07/2017

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F 0241 SS=D Bldg. 00	<p>A Registered Dietitian (RD) Progress note dated 11/29/16 indicated the resident had a significant weight loss in 30 days. The recommendation was to notify the Physician of the trending weight loss.</p> <p>Physician Progress note dated 11/23/16 indicated there was no information regarding a weight loss.</p> <p>Nursing Progress notes dated 11/29-12/8/16 indicated there was no documentation if the Physician was notified of the resident's weight loss.</p> <p>Interview with the C-wing Unit Manager on 12/8/16 at 10:00 a.m. indicated she was off a couple of days last week, and was not aware of the recommendations.</p> <p>Interview with the C-wing Unit Manager on 12/8/16 at 10:45 a.m., indicated the Physician was just notified, and had given a new orders to start the resident on Megace (and appetite stimulant). There was no documentation in the resident's record if the Physician was notified of the weight loss prior to today.</p> <p>3.1-5(a)(2)</p> <p>483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY</p>			

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	<p>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to taking a resident to the bathroom for 1 of 1 residents observed for dignity as well as ensuring a Foley (urinary) catheter drainage bag was covered with a dignity bag for 1 of 3 residents reviewed for urinary catheters of the 4 who met the criteria for urinary catheters. (Residents #121 and #150)</p> <p>Findings include:</p> <p>1. On 12/8/16 at 2:42 p.m., Resident #121 was observed sitting across from the B Wing Nurses' Station in her wheelchair. The resident was yelling "I have to go to the bathroom, I have to go to the bathroom." The Unit Manager and a Physician were at the Nurses' station at that time. The resident was told by the Unit Manager that she would find someone in a minute. The resident continued to yell out that she needed help and she needed to go to the bathroom. A CNA was observed walking past the resident. At 2:50 p.m., the resident was</p>	F 0241	<p>Resident 121 was taken to the bathroom at 2:50 PM by CNA. Resident 150 had foley drainage bag changed to the facility front cover drainage dignity bag by unit manager.</p> <p>A sample interview was conducted by the ED/Designee prior to date of compliance, with residents from various units and shifts to identify any negative trends related to toileting needs.</p> <p>All patients who have a foley catheter were reviewed by nursing department, prior to date of compliance, to ensure appropriate dignity bags were in place.</p> <p>All clinical staff were educated on maintaining dignity specifically related to toileting assistance and catheter bags by DCE.</p> <p>5 resident audits per week X 6 months, will be conducted, on all units and shifts related to patient toileting needs being met and dignity catheter bags being in place.</p> <p>Results of these audits will be taken</p>	01/07/2017

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	<p>assisted to her room by her CNA and taken to the bathroom.</p> <p>The record was reviewed on 12/9/16 at 1:38 p.m. Diagnoses included, but were not limited to, Alzheimer's, chronic kidney disease, and depression.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/25/16, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating cognitive impairment. The resident was an extensive two person assist for transfers, toilet use, and was always incontinent of bowel.</p> <p>The plan of care dated 3/16/16 and reviewed November 2016 indicated the problem of, "due to my dementia, I have an impaired ability to reference length of time accurately, for example 5 minutes feels to me much longer. My family expresses that they have been exceptionally attentive to my needs immediately." The interventions included, but were not limited to, reassure that assistance will be provided, and will respond to the resident as promptly as possible.</p> <p>Interview with the Director of Nursing on 12/9/16 at 12:00 p.m., indicated the resident should have been assisted to the</p>		<p>to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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F 0242 SS=D Bldg. 00	<p>bathroom in a more timely manner.</p> <p>2. On 12/05/16 at 10:55 a.m., Resident #150 was observed in her room seated in a wheelchair. The resident's Foley catheter bag was observed hanging on the side of the wheelchair, not covered by a dignity bag, and could be seen from the hallway.</p> <p>On 12/06/16 at 10:18 a.m., the resident was observed in her room seated in a wheelchair, her Foley catheter bag was uncovered facing the door with yellow urine in it.</p> <p>Interview with the Director of Nursing on 12/09/16 at 2:04 p.m., indicated the resident's Foley catheter bag should have been placed in a dignity bag.</p> <p>3.1-3(t)</p> <p>483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make</p>						

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	<p>choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>Based on observation, record review, and interview, the facility failed to honor a resident's preference related to choosing when to get up in the morning for 1 of 3 residents reviewed for choices of the 5 residents who met the criteria for choices. (Resident #12)</p> <p>Finding includes:</p> <p>During a family interview on 12/5/16 at 11:39 a.m., Resident #12's daughter indicated that staff get her father up in the morning around 5:30 a.m., and she would like him to get up at 6:30 a.m.</p> <p>Interview with CNA #2 on 12/7/16 at 2:03 p.m., indicated he normally works the 2 pm to 10 pm shift, however, he does stay over and work the midnight shift occasionally. The CNA indicated the resident was on the midnight get up list, but he should not be an early get up due to he was not always happy and usually grumpy.</p> <p>On 12/8/16 at 5:20 a.m., CNA #4 and CNA #5 were observed providing</p>	F 0242	<p>Resident 12 immediately had care guide updated to reflect current preferences. This was completed by the unit manager prior to survey exit.</p> <p>All patients who are gotten up during the midnight shift were reviewed to ensure that it was according to their wishes to get up prior to day shift starting. Review completed by clinical department/social services.</p> <p>Licensed staff were educated on resident preferences being honored specific to get up times by the DCE. Patients who are early get ups will be reviewed weely X 6 months to ensure that it's still their preference by social services. All residents will be reviewed and preferences updated on quarterly MDS assessments. This will be ongoing. Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	01/07/2017

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	<p>incontinence care for the resident. The CNA's indicated the resident had come back from the emergency room on their shift so they were not going to get him up at that time. CNA #4 indicated the resident was on the midnight get up list which meant he had to be up by 6:00 a.m. She indicated they usually get him for the day around 5:30 a.m., because sometimes he has been observed trying to get out of bed.</p> <p>The record was reviewed on 12/8/16 at 7:14 a.m. Diagnoses included, but were not limited to, stroke, diabetes, dementia, major depressive disorder, heart failure, high blood pressure, and osteoarthritis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/30/16 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 and was severely impaired for decision making. The resident needed extensive assist with 2 person physical assist for bed mobility, and dressing. He was totally dependent on staff with 2 person assist for transfers, locomotion, eating, and toilet use.</p> <p>The current plan of care updated 9/2016 indicated there was no care plan for the resident's preferences.</p> <p>A CNA care card indicated there was no</p>			

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	<p>information on the care card for the resident to be up at 5:30 a.m.</p> <p>Nursing Progress notes dated July 2016 through December 2016 indicated there was no documentation of the resident trying to get out of bed early in the morning.</p> <p>A resident preference sheet dated 9/28/16 indicated the staff attempted to conduct the interview with the son and the resident, however the son was tearful so the preference sheet was not completed at that time.</p> <p>Interview with the C-wing Unit Manager on 12/8/16 at 10:00 a.m., indicated the resident was getting up right before breakfast (around 7:00 a.m.), but the midnight shift said he was trying to get out of bed. She was unaware if the resident still tried to get out of bed early at the present time.</p> <p>Interview with the Social Service Director on 12/08/16 at 1:07 p.m., indicated she was in charge of completing the resident preference sheet at least quarterly or if there was a recent update.</p> <p>3.1-3(u)(1)</p>			

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F 0247 SS=D Bldg. 00	<p>483.10(e)(6) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE (e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.</p> <p>Based on record review and interview, the facility failed to ensure documentation was completed prior to a roommate change for 1 of 4 residents reviewed for admission/transfer/discharge of the 22 residents who met the criteria for admission/transfer/discharge. (Resident #29)</p> <p>Finding includes:</p> <p>1. Interview with Resident #29 on 12/5/16 at 11:10 a.m., indicated she had a roommate change in the last nine months and was not given notice of the roommate change.</p> <p>The record was reviewed on 12/7/16 at 9:01 a.m. The resident received a roommate on 10/28/16. There was no related documentation the resident was notified before hand.</p> <p>Interview with Social Service Director on 12/8/16 at 3:33 p.m., indicated there was</p>	F 0247	<p>Resident was notified of roommate change but facility failed to document this in the clinical record.</p> <p>Facility reviewed all patient transfers and new roommate occurrences to ensure that appropriate notification was made and documented. The review was conducted for the previous 14 days from date 12.20.16 by social services.</p> <p>All employees involved in decision making for roommate changes were educated on the need to document, on the appropriate forms, prior to a change occurring by the DCE/designee.</p> <p>All roommate changes will be reviewed in the next business day morning meeting for 6 months to ensure notification occurred by social services.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be</p>	01/07/2017
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F 0272 SS=D Bldg. 00	<p>not any documentation that the resident would be receiving a roommate.</p> <p>3.1-3(v)(2)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments</p> <p>(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. 		completed based on QAPI recommendations. If no trends identified then will review on PRN basis.	

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	<p>(xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.</p> <p>Based on record review and interview, the facility failed to ensure the nursing vision assessment was accurate for 1 of 3 residents reviewed for vision of the 55 who met the criteria for vision. (Resident #29)</p> <p>Finding includes:</p> <p>Record for Resident #29 was reviewed on 12/7/16 at 12:43 p.m. Diagnoses included, but were not limited to, subdural hemorrhage, shortness of breath, anemia, heart failure, high blood pressure, and paranoid schizophrenia.</p> <p>The Quarterly Minimum Data Set (MDS)</p>	F 0272	<p>Patient 29 was reassessed by MDS director to ensure appropriate information was coded and care planed regarding her vision.</p> <p>All patients who triggered a vision assessment on most recent comprehensive MDS, for the previous 30 days from 12.20.16, were assessed to ensure accuracy of the vision assessment and vision care plan in place if needed by Social Service/MDS.</p> <p>Education was provided to all licensed nurses regarding an appropriate vision assessment and care plan if needed by DCE.</p> <p>Any patients that trigger vision, dental and audiology assessments, will have the MDS coordinator sign</p>	01/07/2017

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	<p>assessment dated 11/10/16 indicated the resident had modified independence for decision making. The resident needed physical help in the part of bathing with a one person physical assist. Her vision was moderately impaired with no corrective lens.</p> <p>Care Area Assessment (CAA) dated 8/11/16 indicated the resident's vision was impaired and a care plan would be developed.</p> <p>Nursing Admission assessment dated 8/4/16 indicated the resident's vision was adequate.</p> <p>Quarterly Nursing assessment dated 11/10/16 indicated the resident's vision was adequate.</p> <p>Interview with the C-wing Unit Manager on 12/8/16 at 7:29 a.m., indicated she assessed the resident's vision based on an interview with the resident, and she does not make them read anything to ensure the assessment was accurate.</p> <p>Interview with the MDS Coordinator on 12/8/16 at 7:45 a.m., indicated she had completed the MDS assessment for the resident. During the interview, she made the resident read a newspaper or another piece of paper to assess the vision. The</p>		<p>off on the assessment for accuracy and care planning. This will occur for the next 6 months.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>		

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F 0279 SS=D Bldg. 00	<p>MDS Coordinator indicated the resident stated the print was blurry and that was why she was coded as being impaired for vision.</p> <p>3.1-31(a)</p> <p>483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.</p> <p>483.21 (b) Comprehensive Care Plans</p> <p>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and</p>				

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	<p>psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>Based on record review and interview, the facility failed to develop a care plan related to vision based on the comprehensive assessment for 1 of 3 residents reviewed for vision of the 55 residents who met the criteria for vision.</p>	F 0279	<p>Patient 29 was reassessed by MDS director to ensure appropriate information was coded and care planed regarding her vision.</p> <p>All patients who triggered a vision assessment on most recent</p>	01/07/2017

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	<p>(Resident #29)</p> <p>Finding includes:</p> <p>Record for Resident #29 was reviewed on 12/7/16 at 12:43 p.m. Diagnoses included, but were not limited to, subdural hemorrhage, shortness of breath, anemia, heart failure, high blood pressure, and paranoid schizophrenia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/10/16 indicated the resident had modified independence for decision making. The resident needed physical help in the part of bathing with a one person physical assist. Her vision was moderately impaired with no corrective lens.</p> <p>Care Area Assessment (CAA) dated 8/11/16 indicated the resident's vision was impaired, and a care plan would be developed.</p> <p>The current plan of care updated 11/2016 indicated there was no care plan for the resident's impaired vision.</p> <p>Nursing admission assessment dated 8/4/16 indicated vision was adequate.</p> <p>Interview with the MDS Coordinator on 12/8/16 at 7:45 a.m., indicated there was</p>		<p>comprehensive MDS, for the previous 30 days from 12.20.16, were assessed to ensure accuracy of the vision assessment and vision care plan in place if needed by social services/MDS.</p> <p>Education was provided to all licensed nurses regarding an appropriate vision assessment and care plan if needed by DCE.</p> <p>Any patients that trigger vision, dental and audiology assessments, will have the MDS coordinator sign off on the assessment for accuracy and care planning. This will occur for the next 6 months.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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F 0311 SS=D Bldg. 00	<p>no care plan initiated for the resident's impaired vision.</p> <p>3.1-35(a)</p> <p>483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. Based on record review and interview, the facility failed to ensure a resident who needed assistance with bathing received at least two showers a week for 1 of 3 residents reviewed for choices of the 5 residents who met the criteria for choices. (Resident #29)</p> <p>Finding includes:</p> <p>Record for Resident #29 was reviewed on 12/7/16 at 12:43 p.m. Diagnoses included, but were not limited to, subdural hemorrhage, shortness of breath, anemia, heart failure, high blood pressure, and paranoid schizophrenia.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/10/16 indicated the resident had modified independence for</p>	F 0311	<p>Resident care plan was updated by unit manger, prior to date of compliance, to reflect current circumstances. Patient will often refuse showers or forget that she had a shower.</p> <p>Facility reviewed all patient records prior to date of compliance 12.20.16, to identify anyone not receiving 2 showers per week by the nursing department.</p> <p>Education provided to all clinical staff in relation to the need to follow patient preferences and document showers along with refusal of shower DCE/ social services.</p> <p>Shower schedules will be reviewed by the clinical department 2 X per week for 6 months to ensure appropriate action are taken.</p>	01/07/2017

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	<p>decision making. The resident needed physical help in the part of bathing with a one person physical assist. Her vision was moderately impaired with no corrective lens.</p> <p>An Admission MDS assessment dated 8/11/16 indicated it was very important to choose between bath or shower.</p> <p>The shower book indicated the resident was to receive her showers on Tuesdays and Fridays.</p> <p>The only recorded shower for December 2016 was on 12/2.</p> <p>The resident received a shower on 11/11, 11/15, 11/22, 11/25 and 11/29/16. She received a full bed bath on 11/13 and 11/26/16. The resident did not receive at least 2 showers a week.</p> <p>The resident received a shower on 10/4, 10/14, 10/18, 10/25, and 10/31/16. She received a full bed bath on 10/1 and 10/30/16. She did not receive a shower at least two times a week.</p> <p>Interview with the C-wing Unit Manager on 12/8/16 at 9:40 a.m., indicated the resident had not received a shower at least two times a week.</p>		<p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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F 0312 SS=D Bldg. 00	<p>3.1-38(a)(2)(A)</p> <p>483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review, and interview, the facility failed to ensure a resident who was totally dependent on staff for activities of daily living was provided incontinence care at least every two hours for 1 of 2 residents reviewed for activities of daily living of the 2 residents who met the criteria for activities of daily living. (Resident #12)</p> <p>Finding includes:</p> <p>During a family interview on 12/5/16 at 11:46 a.m., Resident #12's daughter indicated her dad only gets changed when they put him to bed. She stated, "one time the wheelchair was soaked and his pampers were dripping when they put him to bed."</p> <p>On 12/7/16 at 8:25 a.m. the resident was observed eating breakfast in the main dining room. At 9:11 a.m., he was</p>	F 0312	<p>Patient 12 was placed on a 3 day voiding pattern by the unit manager, to ensure we had an accurate toileting schedule that met resident needs.</p> <p>All patients who are totally dependent on staff were placed on a 3 day voiding pattern to better assess toileting needs by nursing department.</p> <p>All clinical staff were educated on meeting resident needs related to toileting assistance by the DCE.</p> <p>5 random residents on all shift and units, will be audited by clinical leadership, to ensure toileting needs are being met. This audit will occur for 6 months.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be</p>	01/07/2017

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	<p>brought back to the C-wing and seated in front of the Nurse's station. At 10:09 a.m., the resident was taken back to his room to check for incontinence and then taken down to the activity room.</p> <p>On 12/7/16 at 2:03 p.m., CNA #2 and CNA #3 were preparing to provide incontinence care for the resident. CNA #3 indicated she had taken care of him all day and he was last changed around 10:15 a.m. that morning. The resident's incontinent brief was removed and was saturated with large amounts of urine. He was provided incontinence care and placed in bed.</p> <p>CNA #3 indicated at that time, she had not checked or changed him since earlier in the day. She indicated the resident was up in his wheelchair already dressed when she had arrived to work at 6:00 a.m., and he was not changed before breakfast as well.</p> <p>The record was reviewed on 12/8/16 at 7:14 a.m. Diagnoses included, but were not limited to, stroke, diabetes, dementia, major depressive disorder, heart failure, high blood pressure, and osteoarthritis.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 9/30/16 indicated the resident had a Brief Interview for Mental</p>		<p>completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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F 0322 SS=D	<p>Status (BIMS) score of 3 and was severely impaired for decision making. The resident needed extensive assist with 2 person physical assist for bed mobility, and dressing. He was totally dependent on staff with 2 person assist for transfers, locomotion, eating, and toilet use.</p> <p>The updated current plan of care dated 9/2016 indicated the resident had episodes of incontinence, and was at risk for complications such as a urinary tract infection. The Nursing approaches were to provide assistance with toileting and incontinence care as needed.</p> <p>The CNA care card indicated assist to bathroom every 2 hours even when family was present.</p> <p>Interview with the C-wing Unit Manager on 12/8/16 at 10:10 a.m., indicated residents were to be checked and changed at least every 2 hours. Even if the resident's family was visiting, the CNA's were to ask to take the resident to the bathroom.</p> <p>3.1-38(a)(2)(C)</p> <p>483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE</p>				

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Bldg. 00	<p>EATING SKILLS</p> <p>(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-</p> <p>(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and</p> <p>(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents with Percutaneous Endoscopic Gastrostomy (PEG) tubes received the necessary care and treatments related to medication administration for the 1 of 1 resident reviewed for PEG-tubes. (Resident #160)</p> <p>Finding includes:</p> <p>On 12/08/16 at 10:15 a.m., RN #1 was observed preparing medications for Resident #160. She dispensed the medications from her medication cart and</p>	F 0322	<p>Resident was assessed by the nurse on duty for signs and symptoms of negative outcome from the alleged fail to check PEG tube placement. No findings were noted.</p> <p>all patients who receive medication via peg tube were assessed by the DON/designee with no findings noted.</p> <p>Licensed nurses were educated on proper procedure for verifying placement of peg tube when administering medications by DCE.</p>	01/07/2017

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	<p>poured the contents into two separate pill cups. The RN then walked into the resident's room and donned clean gloves. She then placed a plastic syringe into the resident PEG-tube, and indicated she was checking the tube for residual. The RN was not observed listening for bowel sounds with the stethoscope she had around her neck nor was she observed checking for proper tube placement. The RN then proceeded to check for residual, and administer the resident's medications.</p> <p>Interview at the time with the RN, indicated she did not check for proper placement of the PEG-tube prior to administering the resident's medications.</p> <p>The record was reviewed on 12/08/16 at 10:48 a.m. Diagnoses included, but were not limited to, breast cancer, anxiety, and heart failure.</p> <p>The current care plan indicated the resident required a tube feeding. The interventions included, but were not limited to, check placement per Physician's orders.</p> <p>Interview with the Unit Manager on 12/08/16 at 10:15 a.m., indicated the RN should have checked for proper placement of the resident's PEG-tube prior to administering the medications.</p>		<p>All residents who have medication administered thru their peg tube will be observed 1 X per week for 6 months. The observation will be conducted by DNS/designee.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>		

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F 0323 SS=E Bldg. 00	<p>Review of the current Enteral Tube Medication Administration policy dated 8/2014, provided by the Staff Development Coordinator on 12/08/16 at 1:13 p.m., indicated "With gloves on, check for proper tube placement using air and auscultation only."</p> <p>3.1-44(a)(2)</p> <p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails</p>			

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	<p>with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>Based on observation, record review, and interview, the facility failed to ensure supervision was provided to 3 of 3 residents in the B Wing lounge. The facility also failed to ensure preventative fall measures were in place for 1 of 3 residents reviewed for accidents of the 3 who met the criteria for accidents. (Residents #31, #72, #121, and #236)</p> <p>Findings include:</p> <p>1. On 12/9/16 at 10:20 a.m., five residents were observed in the B Wing lounge area unattended.</p> <p>Resident #72 was repeatedly yelling, "I have to go to the bathroom." Resident #121 was repeatedly yelling, "help me." Resident #236 was attempting to stand from her wheelchair. She indicated that she had to go to the bathroom.</p> <p>At 10:22 a.m., CNA #1 was observed in the hallway. She indicated the residents should not have been left alone in the lounge.</p>	F 0323	<p>Resident 72, 121 and 236 had a CNA come attend to their needs. 236 had fall follow up interventions put in place by the unit manager. Resident 72 is on hospice and they helped intervene during specific times thru out the survey week. Resident 31 had orders updated by PCP prior to exit to indicate she does not require an alarm.</p> <p>Facility leadership did a whole house audit on alarm placement and residents being left unattended that require specific observation.</p> <p>All staff educated on patient safety and fall prevention by DCE.</p> <p>Facility leadership will audit 5 resident alarms and activity observation per week on random halls and shifts.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	01/07/2017

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	<p>At 10:24 a.m., the CNA entered the lounge to assist the residents. At this time, Resident #236 attempted to stand from her wheelchair and fell to the floor.</p> <p>The record for Resident #236 was reviewed on 12/9/16 at 1:15 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, pain in left knee, and repeated falls.</p> <p>The 12/8/16 Admission Minimum Data Set (MDS) assessment, documented the resident's Brief Interview for Mental Status score as 3, indicating cognitive impairment. The resident was identified as being an extensive two person assist for transfers.</p> <p>The plan of care dated 12/2/16, indicated the resident was at risk for falls related to a fall in the past 30 days, history of falls, and new environment.</p> <p>The record for Resident #72 was reviewed on 12/9/16 at 2:03 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, history of falling, and Alzheimer's disease.</p> <p>The 9/30/16 Admission MDS assessment documented the resident's BIMS score as a 4, indicating cognitive impairment.</p>			

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	<p>The resident was identified as being an extensive two person assist with transfers and toileting and was also always incontinent of urine.</p> <p>The resident's current plan of care indicated she was at risk for falls related to a new environment and use of psychoactive medications.</p> <p>The record for Resident #121 was reviewed on 12/9/16 at 1:38 p.m. Diagnoses included, but were not limited to, Alzheimer's, insomnia, chronic kidney disease and depression.</p> <p>The Quarterly MDS assessment dated 11/25/16, documented the resident's BIMS score as a 9, indicating cognitive impairment. The resident was identified as being an extensive two person assist with transfers and toilet use.</p> <p>The plan of care dated 9/15/16, indicated the resident was at risk for falls related to falling in the past 30 days.</p> <p>Interview with the Director of Nursing on 12/9/16 at 12:00 p.m., indicated there had been a CNA in the lounge with the residents but she left for an appointment. Another staff member should have been in the lounge and the residents should not have been left unattended.</p>			

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	<p>2. On 12/6/16 at 3:45 p.m. Resident #31 was observed sitting in her wheelchair. At that time, there was no alarm noted attached to the chair.</p> <p>On 12/7/16 at 11:00 a.m. and 2:52 p.m., the resident was observed sitting in her wheelchair. At that time, there was no alarm noted attached to the chair.</p> <p>On 12/8/16 at 12:51 p.m., the resident was observed sitting in her wheelchair. At that time, there was no alarm noted attached to the chair.</p> <p>Interview with Resident #31 on 12/9/16 at 11:27 a.m., indicated she has never had an alarm on the back of her chair. The staff had suggested it at one time, but she told them, "I do not want it."</p> <p>The record was reviewed on 12/7/16 at 3:08 p.m. Diagnoses included, but were not limited to, cystitis, metabolic encephalopathy, bipolar disorder, and chronic kidney disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated 11/16/16 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she was cognitively intact. The resident had no falls since the last assessment.</p>						

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	<p>The current and updated plan of care dated 11/2016 indicated the resident was at risk for falls related to history of falls. The Nursing approaches included a wheelchair alarm added on 11/28/16.</p> <p>Physician orders dated 11/28/16 indicated wheelchair alarm.</p> <p>Nursing Notes dated 11/26/16 and 11/27/16 indicated the resident was found sitting on the floor near her bed.</p> <p>An IDT note dated 11/28/16 indicated met to discuss the resident's two falls. The resident was treated in emergency room for an urinary tract infection. The resident had increased confusion related to the urinary tract infection, will add a wheelchair alarm to be used at this time do to increased confusion.</p> <p>Nursing Progress notes dated 11/28-12/9/16 indicated there was no documentation regarding the resident refusing to wear the wheelchair alarm.</p> <p>The Treatment Administration Record (TAR) for 12/2016 indicated the wheelchair alarm was being signed out by Nursing staff that it was in place and functioning.</p>			

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F 0328 SS=D Bldg. 00	<p>Interview with LPN #3 on 12/9/16 at 11:30 a.m., indicated she was the nurse taking care of the resident. She was unaware if the resident had a wheelchair alarm or not.</p> <p>Interview with CNA #1 on 12/9/16 at 11:35 a.m., indicated she was taking care of the resident and she did not wear an alarm to her wheelchair.</p> <p>Interview with the B-wing Unit Manager on 12/9/16 at 11:39 a.m., indicated she was unsure if resident was supposed to have an alarm on her wheelchair.</p> <p>Interview with the Director of Nursing (DON) on 12/9/16 at 12:06 p.m., indicated the wheelchair alarm was only a temporary intervention and it had been discontinued today as of now. However, the Nurses should have documented the resident was refusing to wear the alarm.</p> <p>3.1-45(a)(2)</p> <p>483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:</p>			

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	<p>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and</p> <p>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments</p> <p>(f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive</p>			

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	<p>person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents received proper treatment and care related to medication administration for 1 of 1 resident observed for nebulizer treatments. (Resident #232)</p> <p>Finding includes:</p> <p>On 12/08/16 at 11:08 a.m., LPN #1 was observed preparing and administering medications for resident #232 which included, but were not limited to, Ipratropium-Albuterol solution (an inhaled nebulizer medication).</p> <p>The LPN dispensed the medications from her medication cart and entered the resident's room. She then poured the solution into the resident's nebulizing mask and began his breathing treatment. The LPN was not observed assessing the resident's vital signs (pulse, respiration</p>	F 0328	<p>Vitals for patient were taken to clarify that no adverse reactions occurred from self administration of nebulizer treatment by clinical department.</p> <p>Facility leadership identified all residents receiving nebulizer treatments and assessed patients for self administration.</p> <p>Licensed nurses were educated on nebulizer administration policy by the Director of clinical services prior to date of compliance.</p> <p>Facility leadership to observe 5 resident nebulizer treatments per week, for 6 months, on all units and varying shifts to ensure compliance with nebulizer treatments.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends</p>	01/07/2017

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	<p>rate, blood pressure) or lung sounds prior to the treatment, nor did she remain in the resident's room during the entire treatment.</p> <p>Interview at the time with the LPN, indicated she assesses the resident's vitals and lung sounds post treatment, and she was not aware she was supposed to remain in the room with the resident while his treatment was in progress.</p> <p>The record was reviewed on 12/08/16 at 12:12 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (copd) and heart failure.</p> <p>Physician's Order dated 12/03/16 indicated Ipratropium-Albuterol solution 0.5-2.5 (3) mg (milligrams) / (3) ml (milliliters), inhale orally every 4 hours for COPD.</p> <p>Interview with the Director of Nursing (DON) on 12/08/16 at 1:06 p.m., indicated the nurse should have assessed the resident prior to the nebulizer treatment, and remained at the resident's bedside during the treatment per the facility policy.</p> <p>The current Oral Inhalation Administration policy dated 8/2014,</p>		<p>identified then will review on PRN basis.</p>	

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F 0329 SS=D Bldg. 00	<p>provided by the DON on 12/08/2016 at 1:03 p.m., indicated "Obtain baseline pulse, respiratory rate and lung sounds.....Remain with the resident for the treatment unless the resident has been assessed and authorized to self-administer."</p> <p>3.1-48(c)(1)</p> <p>483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated</p>			

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	<p>in paragraphs (d)(1) through (5) of this section.</p> <p>Based on record review and interview, the facility failed to ensure a Gradual Dose Reduction (GDR) was attempted for 1 of 5 residents reviewed for unnecessary medications of the 5 who met the criteria for unnecessary medications. (Resident #46)</p> <p>Finding includes:</p> <p>The record for Resident #46 was reviewed on 12/7/16 at 2:30 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, anxiety disorder, and major depressive disorder.</p> <p>A Physician's order dated 7/4/15 and listed on the December 2016 Physician's Order Summary (POS), indicated the resident was receiving Lexapro (an antidepressant) 10 milligrams (mg) daily for depressive disorder.</p> <p>A Pharmacy recommendation dated 8/29/16, indicated the resident had one psychoactive medication due for a GDR. Lexapro 10 mg every day - depression (written 7/2015).</p> <p>The "No change at this time. Resident is not a candidate for a reduction. Please</p>	F 0329	<p>Resident 46 had his Primary care physician changed on 12.23.16 and the review was conducted with the new MD as the old PCP declined to give a rationale by the unit manager. New MD gave an order to follow the recommendation for the GDR on 12.20.16.</p> <p>Facility leadership did a whole house audit for anyone who had a GDR declined by the MD within the last 30 days, from date 12.20.16, to ensure there was MD rational for the declining of the GDR</p> <p>MDs that attend within the facility were educated on the GDR process and need for rational when declining a pharmacy recommendation for GDR's by ED/designee.</p> <p>All pharmacy GDR recommendations will be reviewed by nursing or social services to ensure that MD's make a rational for all declines of recommendations.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	01/07/2017

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F 0356 SS=D Bldg. 00	<p>document risk versus benefits below or in your progress notes to keep the facility in compliance" column was circled by the Physician.</p> <p>There was no additional documentation on the pharmacy recommendation form related to the reason for refusal of the GDR.</p> <p>Interview with the Director of Nursing on 12/9/16 at 12:00 p.m., indicated there was no reason documented why the Physician refused the resident's GDR.</p> <p>3.1-48(a)(2)</p> <p>483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis:</p> <p>(i) Facility name.</p> <p>(ii) The current date.</p> <p>(iii) The total number and the actual hours worked by the following categories of</p>			

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	<p>licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <p>(A) Registered nurses.</p> <p>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law)</p> <p>(C) Certified nurse aides.</p> <p>(iv) Resident census.</p> <p>(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents and visitors.</p> <p>(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation and interview the facility failed to post the required daily staffing information correctly. This had</p>	F 0356	Facility immediately adjusted the sign to reflect the necessary format.	01/07/2017

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	<p>the potential to affect all residents in the facility.</p> <p>Finding includes:</p> <p>On 12/5/16 at 8:03 a.m. the facility staffing sign was posted on the wall near the main entrance. The staffing sign did not have the name of the facility and did not list the specific hours of each of the three shifts.</p> <p>On 12/6/16 at 9:10 a.m., the facility staffing sign was posted on the wall near the main entrance. The staffing sign did not have the name of the facility and did not list the specific hours of each of the three shifts.</p> <p>On 12/7/16 at 10:22 a.m., the facility staffing sign was posted on the wall near the main entrance. The staffing sign did not have the name of the facility and did not list the specific hours of each of the three shifts.</p> <p>When interviewed on 12/8/16 at 3:38 p.m., the Director of Nursing indicated the staffing sign should have been correctly posted each day.</p> <p>3.1-17(a)</p>		<p>No other areas or residents were identified as being affected</p> <p>Executive Director, Director of nursing, Staff director of education and scheduler reviewed and were educated on F tag 356</p> <p>ED/designee to observed staffing sign 3 X per week for 6 months to ensure compliane.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>				

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F 0371 SS=E Bldg. 00	<p>483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.</p> <p>Based on observation and interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to an accumulation of dirt, dust, and debris on floors, steam tables,</p>	F 0371	<p>All mentioned kitchen sanitation issues were addressed and fixed by the dietary manager prior to date of compliance.</p> <p>Facility utilized the dietician to do a</p>	01/07/2017
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	<p>shelves, and food carts in 1 of 1 Kitchen observed. (The Main Kitchen)</p> <p>Findings include:</p> <p>1. The following was observed during the Brief Kitchen Sanitation Tour on 12/5/16 at 8:55 a.m., with the Dietary Food Manager (DFM):</p> <p>a. The outside of the ice machine was dirty.</p> <p>b. The floor in the walk in cooler was dirty. The caulking was discolored and black. The slats on the tall transportation carts inside the cooler were dirty and sticky to touch. There were trays of food observed on the carts.</p> <p>c. The floor in the freezer was dirty and observed with opened pieces of food on the floor. There was a frozen chicken breast, mixed vegetables and many cups of ice cream containers on the floor.</p> <p>d. The floor in the main kitchen was dirty throughout. The grout was discolored and black.</p> <p>e. There were crumbs noted on the bottom shelf of the steamer.</p> <p>f. The oven doors were sticky to touch</p>		<p>grand walk thru in the kithen to identify any areas not mentioned in the survey.</p> <p>Dietary manager and staff were educated on F tag 371 by the ED/Designee prior to date of compliance.</p> <p>ED/Designee will do a weekly walk thru to review identified area and assure they are addressed immedicaty. This will occur for 6 months or until substantial compliance is maintained.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>and there was a moderate of amount of black substance noted on the inside of both ovens.</p> <p>g. The back splash behind a portable steam table was dirty with food and/or beverage splattered. The glass on that steam table was also dirty and there were food crumbs noted on the top of steam table.</p> <p>2. The following was observed during the Full Kitchen Sanitation Tour on 12/9/16 at 10:11 a.m., with the Dietary Manager:</p> <p>a. There were food crumbs on the floor under food prep tables and in the corners.</p> <p>b. The electric outlet was dirty and greasy on the food prep table.</p> <p>c. The rollers on top of the main steam table were dirty with a heavy accumulation of food crumbs and dried food and/or beverage spillage.</p> <p>d. There was a heavy accumulation of dried food debris observed under the hood of the steam table.</p> <p>Interview with DFM on 12/9/16 at 10:20 a.m., indicated all of the above was in needing of cleaning and or repair.</p>			

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F 0412 SS=D Bldg. 00	<p>3.1-21(i)(3)</p> <p>483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities</p> <p>The facility-</p> <p>(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident:</p> <p>(i) Routine dental services (to the extent covered under the State plan); and</p> <p>(ii) Emergency dental services;</p> <p>(b)(2) Must, if necessary or if requested, assist the resident-</p> <p>(i) In making appointments; and</p> <p>(ii) By arranging for transportation to and from the dental services locations;</p> <p>(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.</p> <p>Based on observation, record review, and interview, the facility failed to ensure dental recommendations were followed</p>	F 0412	Social Services interviewed family and resident and documented their wish not to get dentures at this	01/07/2017

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	<p>up on in a timely manner for 1 of 3 residents reviewed for dental services of the 5 who met the criteria for dental services. (Resident #22)</p> <p>Finding includes:</p> <p>On 12/7/16 at 8:50 a.m., Resident #22 was observed with no dentures in place.</p> <p>The record was reviewed on 12/7/16 at 9:28 a.m. Diagnoses included, but were not limited to, Parkinson's and dysphagia (difficulty swallowing).</p> <p>A Dental progress note dated 6/10/16, indicated the resident requested to see the dentist and was requesting upper and lower dentures. The dentist was waiting on consent for the exam.</p> <p>A Social Service progress note dated 6/10/16, indicated the resident was seen by the dentist per his request. The resident was requesting dentures. Writer will follow up with resident's family.</p> <p>There were no additional dental progress notes available for review.</p> <p>Interview with the Social Service Director (SSD) on 12/9/16 at 10:15 a.m., indicated the resident was last seen by the dentist in June 2016. She indicated the</p>		<p>time.</p> <p>Social services reviewed all patients who received dental services and verified that the list was accurate.</p> <p>Social services department educated on F tag 412 and the need to accurately document patient refusals to follow recommendations.</p> <p>Social services/designee will review dental recommendation 2 X per month for 6 months to ensure they are appropriately addressed.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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F 0441 SS=E Bldg. 00	<p>family may have changed their mind about the dentures and that she would have to check.</p> <p>Interview with the SSD on 12/9/16 at 10:44 a.m., indicated that she talked to the resident's daughter and she didn't want the resident to have dentures. The SSD indicated this should have been documented and followed up in a more timely manner.</p> <p>3.1-24(a)(3)</p> <p>483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.</p> <p>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must</p>			

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	<p>include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to</p>			

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	<p>prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.</p> <p>Based on observation, record review and interview, the facility failed to ensure urinals were stored properly on 1 of 4 units throughout the facility, and lancets were disposed of properly. (C wing)</p> <p>Findings include:</p> <p>1. On 12/6/16 at 10:29 a.m., a urinal was observed on the back of the toilet in the bathroom of Room 224. The urinal was not contained. Two residents used this bathroom.</p> <p>On 12/9/16 at 11:25 a.m., the urinal was again observed on the back of the toilet. The lid was open and the urinal was not contained.</p> <p>Interview with the Director of Nursing on 12/9/16 at 3:00 p.m., indicated the urinal should not have been stored on the back of the toilet.</p> <p>2. On 12/08/16 at 7:40 a.m., LPN #2 was observed preparing to do an Accucheck (blood glucose check) for Resident #56. She then donned clean gloves to both of her hands, grabbed the lancet, a test strip, and the test machine and walked into the resident's room. The LPN removed the</p>	F 0441	<p>The mentioned urinals were properly cleaned and stored prior survey exit by the nursing staff. This was verified by the director of nursing. Nurse who disposed of the lancet improperly was educated on proper disposal of sharps by DON.</p> <p>Facility managers did room rounds to identify any urinals improperly stored. Nursing department rounded all resident room garbage cans to ensure they did not contain any sharps debris.</p> <p>DCE/designee educated all staff related to sharps and urinal storage policies.</p> <p>DON/Designee will review all urinal 1 X per week for 6 months to ensure compliance with storage.</p> <p>DON/Designee will observe sharps disposal weekly for 6 months.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	01/07/2017

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F 0465 SS=E Bldg. 00	<p>cap from the lancet and pricked the resident's finger, obtained the blood, and placed the strip into the Accucheck machine. After she was finished she removed her gloved and rolled them together along with the lancet and threw them all away in the resident's bedside trash can.</p> <p>Interview at the time with the LPN indicated she should have disposed of the lancet into the sharps container.</p> <p>Interview with the Unit Manager on 12/08/16 at 10:15 a.m., indicated the LPN should have disposed of the lancet into the sharps container per the facility policy.</p> <p>The current Syringe and Needle Disposal policy dated 8/2014, provided by the Staff Development Coordinator on 12/08/16 at 1:13 p.m., indicated "Immediately after use, syringes and needles are placed into puncture resistant, one-way containers (sharps) specifically designed for that purpose."</p> <p>3.1-18(b)1</p> <p>483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p>			

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	<p>(h) Other Environmental Conditions</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>(h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.</p> <p>Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred walls, marred doors, chipped paint on heat registers, peeling wall paper, dust on ceiling vents, dead insects inside light covers, food and debris along baseboards, dirty and discolored floor tile, buckled ceiling tiles, and dirty PVC piping on 4 of 4 units throughout the facility and in 1 of 1 kitchen areas. (Units B, C, D, E and Main Kitchen)</p> <p>Findings include:</p> <p>1. During the Environmental tour with the Maintenance and Housekeeping Supervisors on 12/9/16 at 10:56 a.m. thru 11:55 a.m., the following was observed:</p> <p>E wing:</p> <p>a. The bathroom floor tile in Room 309 was discolored. There was also an accumulation of dust and dirt along the</p>	F 0465	<p>All mentioned areas were addressed by maintenance and housekeeping prior to date of compliance.</p> <p>ED did a facility wide review of facility to identify any areas not mentioned in F tag 465. All other findings were addressed.</p> <p>Maintenance and housekeeping managers were educated on F tag 465 by ED.</p> <p>ED/Designee will do a weekly walk thru for 6 month, or until substantial compliance is achieved to ensure the affected areas are maintained.</p> <p>Results of these audits will be taken to QAPI times 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	01/07/2017

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	<p>base board in the bathroom. Two residents used this bathroom.</p> <p>b. The wall next to bed 1 in Room 310 was marred. The closet doors were also scratched and marred. The base of the bathroom door was marred and the non-skid strips in front of the toilet were peeling. Two residents resided in this room.</p> <p>c. The wall next to bed 1 in Room 312 was marred and gouged. Two residents resided in this room.</p> <p>d. The door frame to Room 313 had chipped paint. The wall next to bed 1 was scratched and marred. The window sill had areas of chipped plastic. Three residents resided in this room.</p> <p>e. The door frame to Room 323 had chipped paint. The wall behind the head of bed 1 was scratched and marred. There were areas of chipped plastic along the window sill. The inside of the bathroom door was scratched and marred. Three residents resided in this room.</p> <p>f. The door to Room 324 and the closet doors were scratched and marred. There were large areas of white spackle above bed 2 and the wall was marred by bed 1. Two residents resided in this room.</p>			

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	<p>g. The wall by the bathroom door in Room 326 was gouged and marred. There was cracked floor tile in the bathroom and there were areas of chipped plastic along the window sill. One resident resided in this room.</p> <p>h. The wall behind the head of bed 1 in Room 327 was gouged and marred. The chair in the room was scratched and marred. There was a urine odor in the bathroom. The bathroom door frame had chipped paint. There was a section of peeling paint next to the toilet. Two residents resided in this room.</p> <p>j. The door frame to the "Diner" had chipped paint. The walls were marred throughout. There were sections of peeling base board and there was areas of chipped plastic along the window sill.</p> <p>k. The walls in the Unit Dining Room were scratched and marred. Ten of 10 chairs had scratched and marred arms and legs. The heat register was scratched and marred. The edge of the heat register was bent. The wallpaper border was peeling. There was an accumulation of dust on the ceiling vents. There were dead insects inside the plastic light covers.</p> <p>l. There was peeling wall paper located</p>			

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	<p>next to the hand sanitizer in the Sun Room.</p> <p>D wing:</p> <p>a. The wall next to bed 1 in Room 331 was gouged and marred. The top of the heat register had areas of rust. The closet doors were marred as well as the inside of the bathroom door. Two residents resided in this room.</p> <p>b. The top of the heat register in Room 337 had areas of rust. The dresser, chair and closet doors were scratched and marred. Two residents resided in this room.</p> <p>c. In the Unit Dining Room, the walls and heat register were scratched and marred. The edges of the tables, in the dining room, were scratched and marred.</p> <p>d. The walls and heat register in the Living Room were scratched and marred.</p> <p>The Main Dining Room:</p> <p>a. The heat registers along the baseboards were scratched and marred throughout the dining room.</p> <p>C wing:</p>			

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	<p>a. The bathroom door frame and bathroom door in Room 210 had areas of chipped paint and were marred. One resident resided in this room.</p> <p>b. The bathroom door frame had areas of chipped paint in Room 211. One resident resided in this room.</p> <p>c. The bathroom door frame and the bathroom door in Room 222 had areas of chipped paint. Two residents resided in this room.</p> <p>d. There was a hole in the closet door in Room 223. The bathroom door frame and bathroom door had areas of chipped paint. Two residents resided in this room.</p> <p>e. The inside of the bathroom door in Room 224 was scuffed and marred. The door frames were also scratched and marred. Two residents resided in this room.</p> <p>f. The inside of the bathroom door in Room 228 was scuffed and marred. Two residents resided in this room.</p> <p>g. The bathroom door in Room 229 was scuffed and marred. Two residents resided in this room.</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 3175 LANCER ST PORTAGE, IN 46368
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	<p>h. The heat register in Room 230 was scratched and marred. The inside of the bathroom door was scratched and marred. Two residents resided in this room.</p> <p>B wing:</p> <p>a. The inside of the bathroom door in Room 101 was scratched and marred. The floor mat located next to bed 1 was stained. Two residents resided in this room.</p> <p>b. The walls in the bathroom of Room 106 were scratched and marred. The edge of the wall by the bathroom door was scratched and marred. The arms and legs of the chair were scratched and marred. One resident resided in this room.</p> <p>c. The arms and legs of the chair located next to bed 1 in Room 108 were scratched and marred. The base of the closet doors were scratched and marred. The walls in the bathroom were scratched and marred and the door frame had areas of chipped paint. The privacy curtain next to bed 2 was off track. Two residents resided in this room.</p> <p>d. The wall behind the head of bed 1 in Room 110 was scratched and marred. The base of the bathroom door was</p>			

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	<p>scratched and marred . The floor mat next to bed 1 was stained. Two residents resided in this room.</p> <p>e. The bathroom door in Room 111 was scratched and marred. The wall behind the head of bed 2 was gouged and marred. Two residents resided in this room.</p> <p>f. The wall located next to bed 2 in Room 112 was scratched and marred. The bathroom door and closet door were scratched and marred. One resident resided in this room.</p> <p>g. The wall behind the head of bed 2 in Room 115 was gouged and marred. One resident resided in this room.</p> <p>h. In the bathroom of Room 121 the base board was loose and peeling away from the wall, and behind the toilet. The closet door was scratched and marred. The heat register had areas of chipped paint. The wall behind the head of bed 2 was gouged and marred. Two residents resided in this room.</p> <p>j. The wall behind the recliner in Room 123 was gouged and marred. The light bulb in the bathroom light fixture was dull. The corner of the wall behind the toilet was discolored. The base of the</p>			

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	<p>heat register was scratched and marred. Two residents resided in this room.</p> <p>k. An accumulation of dust was observed on top of the heat register in Room 124. The closet door was scratched and marred. The base board was loose and pulling away from the wall behind the toilet. One resident resided in this room.</p> <p>l. The heat register in Room 128 had areas of chipped paint and scuff marks. The base of the bathroom door was scratched and marred. The floor mats located next to both beds were stained. Two residents resided in this room.</p> <p>m. The bathroom door frame had areas of chipped paint in Room 130. The base of the bathroom door was also scratched and marred. Two residents resided in this room.</p> <p>Interview with the Maintenance Supervisor on 12/9/16 at 11:55 a.m., indicated all of the above areas were in need of cleaning and/or repair.</p> <p>2. The following was observed during the Brief Kitchen Sanitation Tour on 12/5/16 at 8:55 a.m., with the Dietary Manager:</p> <p>Main Kitchen:</p> <p>a. There was a large amount of food and</p>			

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	<p>debris adhered along the baseboard under the 3 compartment sink and the dish machine.</p> <p>b. There were dead insects noted on the window sill in the dish room.</p> <p>c. The floor tile was dirty in the dish room, the grout was also noted to be dirty and colored black.</p> <p>d. The outside of the garbage can by the hand washing sink was dirty under the lid, and noted to be black in color.</p> <p>e. There were food crumbs noted and a breadstick under the dish machine.</p> <p>f. The ceiling vent in the ice room was dirty with black dust.</p> <p>g. The ceiling in the ice room was dirty and the paint was buckling.</p> <p>h. The floor under the food prep table was dirty where the garbage disposal was observed. There was adhered dirt noted on the floor tile, and the white PVC pipe under the food prep table was dirty.</p> <p>3. The following was observed during the Full Kitchen Sanitation Tour on 12/9/16 at 10:11 a.m., with the Dietary Manager:</p>			

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F 9999 Bldg. 00	<p>Main Kitchen:</p> <p>a. The accordion metal door window had a large accumulation of dried food and/or beverage spillage noted all around it.</p> <p>Interview with the DFM on 12/9/16 at 10:20 a.m., indicated all of the above was in needing of cleaning and or repair.</p> <p>3.1-19(f)</p> <p>410 IAC 16.2-3.1-14 Personnel</p> <p>The facility must assure the following: (1) At the time of employment, or within one (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 testing should employ the two-step method. If the first step is negative, a</p>	F 9999	<p>The affected employees immediately had their Mantoux test initiated and read according to guidelines by the DCE.</p> <p>Director of clinical education reviewed all employee Mantoux records and identified anyone not in compliance.</p> <p>DON designee will educate all staff related to TB testing.</p> <p>DCE/Designee will have an ongoing audit to address Mantoux compliance for new and existing</p>	01/07/2017	

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	<p>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.</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to ensure personnel records were complete, related to Mantoux tuberculosis (TB) testing for 3 of 10 employee files reviewed. (CNA #6, LPN #3 and LPN #4)</p> <p>Finding includes:</p> <p>The employee files were reviewed on 12/9/16 at 3:15 p.m.</p> <p>CNA #6 was hired on 9/16/15 and her annual TB skin test was not completed for 2016.</p> <p>LPN #3 was hired 10/13/15 and her annual TB skin test was not completed for 2016.</p> <p>LPN #4 was hired 10/4/16 and her 1st step TB skin test was not completed.</p> <p>Interview with the Director of Clinical</p>		employees.	

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	Education on 12/9/16 at 3:55 p.m., indicated the TB skin tests should have been completed in a timely manner.				