STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(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
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00134743 and IN00133532. This visit resulted in an extended survey-substandard quality of care. Complaint IN00134743-unsubstantiated due to lack of evidence. Complaint IN00133532-substantiated, Federal/Sate deficiencies related to the allegations were cited at F280, F315, F325, F353, F465, and F520. Survey dates: September 9, 10, 11, 12, 13, 16, 2013 Extended Survey dates: September 17 & 18, 2013 Facility number: 000376 Provider number: 155717 AIM number: 100275510 Survey team: Shannon Pietraszewski, RN TC Lora Brettnacher, RN (September 10, 11, 12, 13, 16, 17, and 18, 2013) Jeanna King, RN (September 9, 11, 12, 13, 16, 17, and 18, 2013)	F000000		

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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	Census bed type: SNF/NF: 38 Total: 38 Census Payor type: Medicare: 0 Medicaid: 35 Other: 3 Total: 38 Residential sample: 23 Extended sample: 7 There deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 09/30/2013 by Brenda Marshall Nunan, RN			

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F000156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:			

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	A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,			

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	and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide correct Skilled Nursing Facility Denial Letters and/or failed to notify cognitively alert residents or the beneficiaries of cognitively impaired residents of Medicare Non-Coverage of services no later than 2 days before services ended for 9 of 11 residents reviewed for notification of Medicare Non-Coverage for skilled services. The facility also provided Medicare Non-Coverage letters which indicated a date prior to residents' admission as notification for 2 of 11 residents reviewed for Medicare Non-Coverage for skilled services. (Residents #2, #28, #32, #35, #38, #41, #46, #47, #48, #54 and #55) Findings include: 1. Resident #38's Admission MDS (Minimum Data Set) Assessment dated 1/17/13, indicated Resident #38 was admitted to the facility on 1/10/13 from an acute care hospital. The MDS Assessment indicated occupation and physical therapy were started on 1/11/13. The Quarterly MDS Assessments dated 4/8/13 and 7/3/13, did not indicate when occupational and physical therapy	F000156	F156 Were other residents identified with potential to be affected by the deficiency? All residents that are currently receiving Medicare benefits have been identified. These residents are being reviewed by the IDT at least weekly to assure that when the determination is made that the ending of Medicare benefits is near that the resident/Responsible person receives proper notice on the appropriate form What measures and systemic changes were put in place to assure deficient practice does not recur? The appropriate form has been obtained related to residents being ineligible for Medicare benefits and their appeal rights. The Business Office Manager has been in-serviced related to the use of the appropriate forms to utilize when the end of Medicare coverage occurs and requirement of providing 2 day notice. In the morning IDT meeting at least weekly, residents currently receiving Medicare benefits will be reviewed to assure that all IDT members are aware so that proper notice can be implemented. Were any in-services/education provided to address deficient practice? The Business Office Manager has been in-serviced related to utilizing the proper form for ending of Medicare benefits. The	10/17/2013

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	services were discontinued. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 4/2/13, did not indicate Resident #38's date of admission. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 4/19/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed by the resident who was severely cognitively impaired. 2. Resident #54's Admission MDS Assessment dated 3/8/13, indicated the resident was admitted from an acute care hospital. The MDS Assessment indicated the resident's occupational therapy was started on 3/11/13 and physical therapy was started on 3/10/13. The MDS		IDT team has been in-serviced related to weekly review of all Medicare residents so that a team determination can be made when Medicare benefits may be coming to the end. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents (if applicable) whose Medicare benefits have ended. This form will be completed weekly x3, monthly x3, and then quarterly x3. The Administrator, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy is appropriate. The Business Office Manager and the IDT team have been re-in-serviced on the current policy. F156 Were other residents identified with potential to be affected by the deficiency? All residents that are currently receiving Medicare benefits have been identified. These residents are being reviewed by the IDT at least weekly to assure that when the determination is made that the ending of Medicare benefits is	

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	Assessment indicated the resident was cognitively intact. The Discharge MDS Assessment dated 3/13/13, indicated the resident was transferred to another nursing home or swing bed facility. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 2/27/13 [sic], did not indicate Resident #54's date of admission. The MDS (Minimum Data Set) Assessment indicated the resident was admitted into the facility on 3/8/13 [sic]. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 3/13/13. The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. 3. Resident #55's Admission MDS Assessment dated 7/31/12 indicated the resident was admitted from an acute care hospital. The Discharge MDS Assessment dated 2/4/13,		near that the resident/Responsible person receives proper notice on the appropriate form What measures and systemic changes were put in place to assure deficient practice does not recur? The appropriate form has been obtained related to residents being ineligible for Medicare benefits and their appeal rights. The Business Office Manager has been in-serviced related to the use of the appropriate forms to utilize when the end of Medicare coverage occurs and requirement of providing 2 day notice. In the morning IDT meeting at least weekly, residents currently receiving Medicare benefits will be reviewed to assure that all IDT members are aware so that proper notice can be implemented. Were any in-services/education provided to address deficient practice? The Business Office Manager has been in-serviced related to utilizing the proper form for ending of Medicare benefits. The IDT team has been in-serviced related to weekly review of all Medicare residents so that a team determination can be made when Medicare benefits may be coming to the end. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents (if applicable) whose Medicare benefits have ended.	

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	indicated occupational and physical therapy started on 8/1/12 and were discontinued on 2/4/13. The MDS Asssessment indicated the resident was moderately cognitively impaired. The Discharge MDS Assessment indicated the resident had an unplanned discharge to the community. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 2/3/13, did not indicate Resident #55's date of admission. The letter indicated Medicare coverage ended 2/3/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." The letter indicated "...B. I do not want my bill services I continue to need for submission to the intermediary for Medicare decision [sic]." The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed by the resident who was moderately cognitively impaired. 4. Resident #35's Admission MDS		This form will be completed weekly x3, monthly x3, and then quarterly x3. The Administrator, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy is appropriate. The Business Office Manager and the IDT team have been re-in-serviced on the current policy. Reason for IDR :After review of the facility rooster and the stage 2 sample resident list there are no way to identify the residents to respond to the citation. F 156– No Catheter, Prevent UTI, Restore Bladder It is the policy of the Alpha Home to Corrective Action Taken Related to this Finding: The Alpha Home is not able to respond to this tag number since no resident #38, #46, # 54, and #55 is not listed on the stage 2 sample resident list. Residents of the Alpha Home receiving Advanced Beneficiary Notice letter shall have their letter dated, admission date included, Medicare billable service, name and address of the intermediary, language with their appeal rights	

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	Assessment dated 3/19/13, indicated the resident was admitted to the facility on 3/12/13 from an acute care hospital. The MDS Assessment indicated occupation and physical therapy were started on 3/13/13. An unscheduled MDS Assessment dated 3/28/13, indicated occupational and physical therapy ended on 3/28/13. The MDS Assessment indicated the resident was severely cognitively impaired. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 2/27/13 [sic], did not indicate Resident #35's date of admission. The MDS Assessment indicated the resident started physical and occupational therapy on 3/13/13. The letter indicated Medicare coverage would end beginning 3/27/13. The MDS indicated the resident last day of physical and occupation therapy was 3/28/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." "...B. I do not want my bill services I continue to need for submission to the intermediary for Medicare decision [sic]." The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would		listed on the form. There is no resident # 54 listed on the on the stage 2 sample resident list. The advance beneficiary notice letter will include language to allow residents to appeal, date of admission, and the name and address of the intermediary for appeal. Resident #35 has relocated from the Alpha Home. Resident # 47 and family to receive new form notification letter to acknowledge name and address of the intermediately , resident appeal rights ,and with Beneficiary dates of service, appeal rights, and therapy termination service dates. II. Other Residents with Potential to be affected by this finding will be identified by: Audited review of their Medicare review letters. Residents of the Alpha Home who received advanced beneficiary notice letters have the potential to be affected by these findings. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All the residents who received advanced beneficiary letters, audits have been completed. New letters will include the names and addresses of the intermediary, the resident right for appeal, the signature of the officer and the signature of the resident or responsible party. Care Plans will additionally address new physician orders, significant, changes , updated progress noted from service	

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	not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed by the resident who was severely cognitively impaired. 5. Resident #32's Admission MDS (Minimum Data Set) Assessment dated 3/29/13, indicated the resident was admitted to the facility on 3/22/13 from an acute care hospital. The Significant Change MDS Assessment dated 4/26/13, indicated occupational therapy was started on 3/25/13 and physical therapy was started on 3/22/13. The Discharge MDS Assessment dated 7/18/13, did not indicate with therapy was discontinued. The MDS Assessment indicated the resident was cognitively intact. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 3/28/13, did not indicate Resident #32's date of admission. The letter indicated Medicare coverage would end beginning 4/29/13. "...B. I do not want my bill services I continue to need for submission to the intermediary for Medicare decision [sic]." The letter did not indicate the name and address of the intermediary. The		provides and contributing information that address the resident care. The unit manager will continue to monitor the twenty four reports with the audit sheets for communication and compliance with review with the Director of nurse. All care plans are reviewed for additional input from the audit sheets, behavior sheets, and direct care assignment sheets. The audit sheets, and resident updates are communicated to the staff. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by. The interdisciplinary each week to conduct correct action review of the audits. These daily audit sheets completed by the nurses, and reviewed by the interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. V. Corrected Action Completion	

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	letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. 6. Resident #47's Admission MDS Assessment dated 2/25/13, indicated the resident was admitted into the facility on 2/18/13. The Quarterly MDS Assessment dated 4/29/13, indicated occupational and physical therapy were started on 2/19/13. The Quarterly MDS Assessment dated 4/29/13 and 7/22/13, did not indicate when occupational and physical therapy ended. The MDS Assessment indicated the resident was severely cognitively impaired. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 4/14/13, did not indicate Resident #47's date of admission. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 4/30/13. The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare		Date 10/17/13	

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	appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed with an "X" by the resident who was severely cognitively impaired. Another "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 4/1513, did not indicate Resident #47's date of admission. The letter indicated "...indicated [Name of Resident #47] no longer qualifies as coverage under Medicare beginning 4/29/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." The letter indicated "...B. I do not want my bill services I continue to need for submission to the intermediary for Medicare decision [sic]." The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed with the resident's name who was severely cognitively impaired. 7. Resident #41's Discharge MDS dated 4/3/13, indicated the resident			

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	was discharged to an acute care hospital. The MDS Assessment indicated the resident was originally admitted to the facility on 10/7/12. A Quarterly MDS Assessment dated 7/1/13, indicated the resident re-entered the facility on 4/12/13. The MDS Assessment indicated occupational and physical therapy were started on 4/15/13 and ended on 6/28/13. The MDS Assessment indicated the resident was cognitively intact. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 6/14/13, did not indicate Resident #41's date of admission. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 6/29/13. The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. 8. Resident #46's Admission MDS Assessment dated 2/19/13, indicated			

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	the resident was admitted on 2/12/13 from the community. The Discharge MDS Assessment dated 4/13/13, indicated the resident had an unplanned discharge to an acute care hospital. The MDS Assessment indicated occupational and physical therapy started on 2/13/13 and ended on 4/12/13. The Re-Entry MDS Assessment indicated the resident returned from the hospital on 4/22/13. The Discharge MDS dated 5/20/13, indicated the resident had an unplanned discharge to an acute care hospital. Occupational and physical therapy was started again on 5/1/13. The Re-Entry MDS Assessment indicated the resident returned from the hospital on 5/24/13. A Significant Change MDS Assessment dated 5/31/13 and the Discharge MDS Assessment dated 6/4/13, did not indicate when occupational and physical therapy ended. The MDS Assessment indicated the resident was severely cognitively impaired. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 5/27/13, did not indicate Resident #46's date of admission. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under			

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	Medicare beginning 6/4/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed by the resident who was severely cognitively impaired. 9. Resident #2's Quarterly MDS Assessment dated 2/11/13, indicated the resident re-entered the facility on 8/16/12. The 2/11/13 and 5/3/13 Quarterly MDS Assessment as well as the 7/25/13 Annual MDS Assessment did not indicate the resident was receiving any type of skilled services. The MDS Assessment indicated the resident was severely cognitively impaired. Review of "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 8/12/13, did not indicate Resident #2's date of admission. The MDS (Minimum Data Set) Assessment indicated the resident			

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	was admitted into the facility on 8/26/12. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 3/13/13. The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. 10. Resident #48's Discharge MDS Assessment dated 7/1/13, indicated the resident was discharged to the community. The MDS Assessment indicated the resident was admitted to the facility on 3/26/13. Occupational and physical therapy was started on 3/26/13. The Discharge MDS Assessment did not indicate when occupational and physical therapy ended. The MDS Assessment indicated the resident was severely cognitively impaired. Review of the Occupational and Physical therapy discharge note indicated the resident was receiving Occupational and Physical therapy			

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	services until 6/28/13. A Medicare Non-Coverage form was not provided by the facility. 11. Resident #28's Admission MDS Assessment dated 7/1/13, indicated the resident was admitted to the facility on 6/20/13 from another facility. The MDS Assessment indicated physical therapy was started on 6/25/13. A therapy consent form from [name of therapy company] dated 6/22/13, indicated the resident was going to receive occupational and physical therapy services under Medicare Part A. A physician clarification order dated 6/25/13, indicated PT (physical therapy) three times a week for four weeks. A physician clarification order dated 6/27/13, indicated OT (occupational therapy) three times a week for four weeks. During an interview on 9/13/2013 at 8:08 A.M., the facility's previous rehabilitation provider's (PRP) Staff #1 indicated their company terminated service contract on June 30, 2013.			

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	A Medicare Non-Coverage form was not provided by the facility. The Administrator was interviewed on 9/18/13 at 4:00 p.m. The Administrator indicated he had been doing the Skilled Nursing Facility Denial Letter and the Notice of Medicare Non-Coverage letters for several months. The Administrator indicated he was not aware of the incorrect resident names and dates on the notice letters as well as the proper verbage or regulated information that was to be provided to the resident and family upon skilled services being discontinued. The Administrator was not able to indicate if Resident #2 had Medicare Skilled Services. 3.1-4(a) 3.1-4(f)(3)			

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview, record review, and policy review, the facility failed to notify family members/and or residents that recommended therapy services were not available for 2 of 5	F000157	F157 Were other residents identified with potential to be affected by the deficiency? There most likely other residents affected by this deficiency. However, the facility currently is	10/16/2013

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	residents reviewed for termination of therapy services (Resident #49 and #28). Findings include: 1. Resident #49's record was reviewed on 9/13/2013 at 9:30 A.M. Resident # 49 had diagnoses which included, but were not limited to, myopathy (possible Gillian Barre), autism, and malnutrition. A care plan note dated 3/20/2013, indicated Resident #49 was admitted to the facility for skilled nursing and therapy services with discharge plans to go home. An un-timed IDT progress note dated 6/18/2013, indicated Resident #49 continued with PT/OT (physical therapy/occupational therapy) services. Resident #49 had made progress and would continue with therapy services. A physician's order dated 7/2/2013-3:50 P.M., indicated, "Late entry for 6/28/2013, D/C (discontinue) from skilled OT/PT at maximal functional level. Recommendation to restorative nursing for therapeutic exs (exercises) all extremities, monitor wrist splints-6/wk X 6/wks (six times a		offering all therapy services and all residents are receiving therapy in accordance with the physician's orders. If there were to be any change in this situation, all resident families would be notified appropriately What measures and systemic changes were put in place to assure deficient practice does not recur? All orders, including orders for therapy services, are being reviewed each business morning by the IDT team. The IDT team has been in-serviced related to assuring that all therapy services are occurring in accordance with the physician's orders. At the present time, the facility has therapy services and residents are receiving services appropriately. If for any reason this would change, the IDT team has been trained that family notification must occur Were any in-services/education provided to address deficient practice? The IDT team has been in-serviced related to assuring that therapy services occurs as order for the residents. If at any time there would be a reason that this could not occur, the IDT team is aware that family notification must occur. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents who currently have therapy orders. This form will be completed weekly x3, monthly x3, and then quarterly	

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	week for six weeks) starting 7/8/2013." During an interview on 9/13/2013 at 9:40 A.M., PRP (previous therapy provider)Therapist #2 indicated Resident #49 was actively participating in therapy terminated services with the facility. PRP Therapist #2 indicated Resident #49 would have continued to make progress with therapy rehabilitation. "... She was a young lady who came down with a progressive disease that was reversible with therapy. She was transferred to another facility because her family was tired of waiting for therapy." During a phone interview on 9/13/2013 at 12:20 P.M., Resident #49's mom stated, "She was getting therapy. In the month of July they stopped. I started noticing she wasn't getting therapy. No, they didn't tell me. She required it. I began to ask and they said therapy was gone... "Resident #41's mom indicated she moved her daughter to another facility on August 1, 2013, because of the lack of therapy services. She indicated the new facility provided her with the proper therapy services and her daughter had improved.		x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy is appropriate. Training occurred based on current facility policy II. Other Residents with the potential to be affected by this finding will be identified by: All residents in the facility that are identified as being affected by this finding have new therapy orders and have been seen by the therapist and programs initiated as indicated. . III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All residents will have therapy orders addressed upon receipt. Therapy will be notified the same day the orders are received. Communication of these orders or any recommendation s will take place through the 24 hour sheet for nursing and discussed daily in the interdisciplinary team meeting. IV. Corrective Actions will be monitored to Ensure Compliance by: The	

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	During an interview on 9/12/2013 at 4:00 P.M., the DON was asked to provide documentation Resident #49's mom had been notified that therapy services had been discontinued because the therapy company had left. During an interview on 9/18/2013 at 2:10 P.M., the DON indicated the facility failed to notify Resident 49's mother that therapy services had been discontinued. 2. Resident #28's record was reviewed on 9/13/13 at 9:45 a.m. Resident #28's diagnoses included, but were not limited to CVA (stroke), weakness, and an unsteady gait. A physician clarification order dated 6/25/13, indicated skilled PT (physical therapy) three times a week for four weeks to improve functional mobility and pain management via therapy, exercises, therapeutic activity, gait/transfer training, balance activities and modalities as indicated. A physician clarification order dated 6/27/13, indicated OT (occupational therapy) three times a week for four weeks to increase independence with ADL's (Activities of Daily Living) and increase independence with		charge nurse will be responsible for assuring that these policies and procedures be carried out with each resident, The DON will monitor for compliance and report no less than quarterly to the quality assurance committee. V. Completion Date: *10-16-13	

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	wheelchair mobility, using there exercise, therapeutic activities, modalities and self care retraining. An interview with the therapy company on 9/11/13 at , indicated they had stopped therapy services within the facility on July 30, 2013. Restorative nursing was to be provided until further arrangements for continued therapy could be provided. A physician order dated 8/15/13, indicated OT/PT evaluation and treat as needed. A physician clarification order dated 8/23/13, indicated OT/PT evaluations were completed. OT/PT had recommended for the resident to be seen three times a week for four weeks for ADL retraining, therapeutic exercise and activities, gait training and home assessment. . Resident #28's daughter was interviewed on 9/13/13 at 11:10 a.m. Resident #28's daughter indicated she was the contact person for all orders and changes in condition. The daughter indicated Resident #28 would be receiving restorative nursing two weeks after Resident #28's admission. The daughter indicated			

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	she was not contacted regarding therapy services providing care and stopping care during the month of June and July 2013. The daughter also indicated she was not informed of a new therapy company coming into the facility and providing services to Resident #28 from August 2013 to current. 3.1-5(a)(3)			

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F000159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that			

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	receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.			
	Based on interview the facility failed to provide residents with availablilty of funds on weekends for 4 of 17 residents/families interviewed regarding availability of funds. This had the potential to affect all 33 out of 38 residents who reside in the facility. Findings include: During an interview on 9/9/13 at 10:50 a.m., Resident #50 indicated he did not know if he was able to withdraw funds on the weekends. During an interview on 9/10/13 at 10:37 a.m., Resident #10 indicated the office was closed on the weekends. During an interview on 9/10/13 at 2:25 p.m., Resident #4 indicated "the big man" was gone on the weekends and he was the one who handled the money. During an interview on 9/11/13 at	F000159	F159 Were other residents identified with potential to be affected by the deficiency? All residents with resident funds managed by the facility have been identified. These residents have been notified that there will be banking hours available on both Saturdays and Sundays. What measures and systemic changes were put in place to assure deficient practice does not recur? The facility has changed its banking hours to include Saturday and Sunday. The information on these new hours has been communicated to all residents that currently have a resident trust account that is managed by the facility. Letters have been sent to responsible persons for residents as applicable notifying them of this change in protocol. The Administrator will be responsible for assuring that this occurs Were any in-services/education provided to address deficient practice? The Business Office Manager has been in-serviced related to assuring money is available from the resident trust accounts during weekend hours.	09/28/2013

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	11:00 a.m., Resident #37 indicated she was not able to withdraw funds on the weekends due to the office being closed. During an interview on 9/13/2013 at 1:43 P.M., the DON (Director of Nursing) indicated the facility's banking hours were Monday through Friday 9:00 A.M. to approximately 4:30 P.M.. The DON stated, "No, we do not have a system for residents to get money weekends. The system is if they want money on weekends they have to get it on Friday." 3.1-6(f)(1)		Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents who currently have resident trust accounts. The form will interview resident/responsible persons to assure that they understand that their funds are available on the weekends. This form will be completed weekly x3, monthly x3, and then quarterly x3. The Administrator, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The policy was amended to include the availability of resident trust money during weekend hours. F -159 FACILITY MANAGEMENT OF PERSONAL FUNDS It is the policy of the Alpha Home with written authorization by the resident or family to establish safeguard manage and account for personal funds of the deposited within the facility, Corrective Action related to this finding: The Alpha Home has established business weekend hours on Saturday and Sunday for resident	

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			requesting to withdraw money. each day of the weekend to withdraw a dollar. Resident still have the option of withdrawing money on Friday for the weekend without returning F II. Other Residents with Potential to be affected by this finding will be identified by: All other residents with bank accounts have this potential to be affected by this finding; however, no other residents were affected. . III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Designated staff person on Saturday and Sunday to distribute resident request for money in the activity room or the front office. Residents notified at resident council that money is available for withdrawal. Families notified with a letter identifying access to resident personal funds. IV. Corrective Actions will be monitored to Ensure Compliance by: The Administrator will monitor compliance with the resident personal disbursement to ensure the accessibility to the account is completed. All noncompliance submitted to the Quality Assurance at its regular scheduled monthly meeting. This practice will be on going for the next three months. The Quality Assurance Committee will review and make recommendation for continuous quality improvements, for the next quarter with the	

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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
			committee will determining if additional recommendation is necessary. Completion Date: 09/28/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/16/2013
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222	

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F000223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was free from physical abuse. This deficient practice affected 1 of 3 residents who alleged they were abused by staff (Resident #41). Findings include: Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Resident #41 had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, a history of a stroke with left sided weakness, and seizures. A quarterly Minimum Data Set Assessment Tool (MDS) dated 7/1/13, indicated Resident #41 was cognitively intact with a BIMS (brief interview mental status cognition assessment tool) score of 14., totally dependent on the assistance of one staff for locomotion, dressing, personal hygiene, bathing, transfers, and toileting.	F000223	F223 Were other residents identified with potential to be affected by the deficiency? There have been no other residents identified related to this deficiency What measures and systemic changes were put in place to assure deficient practice does not recur? The policy related to abuse has been re-in-serviced to assure a thorough understanding of the regulation including the reporting of unusual occurrences in a timely manner to the administrator. All staff has been in-serviced related to the policy. The Administrator is responsible for assuring that all allegations of abuse are thoroughly investigated and reported in a timely manner in accordance with the regulation. Were any in-services/education provided to address deficient practice? All staff has been in-serviced related to abuse prevention and reporting to Administrator and appropriate agencies in accordance with the policy. Was a monitoring system implemented to ensure the deficient practice does not occur?	10/17/2013

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	A record titled 'Care Plan Meeting Sign in Sheet" dated 5/30/2013, indicated staff present for the meeting included the DON, Administrator, Social Service Director, and Resident #41. This record indicated, "... Res (Resident) says sit on edge of bed, Lt (left) knee were buckle on his own. Aide grabbed et threw in w/c before breakfast. Says grabbed around under arms (bear hug) picked up from bed et threw in chair. Resident rushed to dining DR.... Had therapy/look at arm/shoulder. Res says this has happened more than once.... Allegation against employee-employee suspended...." During an interview on 9/10/2013 at 2:03 P.M., Resident #41 indicated a staff member had abused him. Resident #41 stated, "He is gone now. Three months ago. Don't remember his name. It was an aide. He picked me up and slung me around. He threw me in the chair. I told him I got a bad shoulder. He picked me up by my bad shoulder. I told him to use the gait belt or put me on the lift. He (said he) didn't have to use the lift. He was superman. He did it twice. I had to report him. They chewed him out but he is gone because I wasn't the only one he was		An audit tool has been completed that reviews any unusual occurrences including abuse policy to assure that it was thoroughly investigated, protocol was followed, and it was reported properly. The Administrator, or designee, is responsible for completion of the tool. This tool will be completed weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately. The facility will continue weekly monitoring if negative findings are identified as a result of the audit until compliance is reached. The tools will be reviewed at the regularly scheduled meetings with recommendations as needed based on the outcome of the audits. Were any policies developed or amended to address the deficient practice? The policy already included proper reporting related to abuse. Additional training occurred. F- 223 INVESTIGATE/REPORT ALLEGATIONS INDIVIDUALS The Alpha Home policy is to not employ individuals who have been found guilty of abusing neglecting or mistreating residents by a court of law. Also to report allegation of mistreatment to State officials and state agency. Corrective Action related to this finding: Prior to being hired Alpha Home checklist is in place to prevent new staff from starting without	

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	doing it to. I told the nurse and the DON (Director of Nursing). Takes awhile. He knew how to do the job right but he was in a hurry so he was just going to slam me around so he could go on to the next person. So did he do it to intentionally to hurt me or did he do it because he wasn't doing his job right. I would have to put a question mark at the end of that question." During an interview on 9/16/2013 at 2:30 P.M., with the Social Service Director (SSD), the DON, and the Administrator present, the following information was requested: 1) A list of all allegations of abuse for the last three months. 2) Any grievances specifically regarding Resident #41 and his allegation of abuse regarding a staff "throwing him in a chair." The Administrator indicated he did not think there had been any but he would look. During an interview on 9/18/2013 at 12:06 P.M., the DON indicated Resident #41 complained about everyone. The DON stated, "First allegation I heard when he put him the chair. He was rough with him. I can't remember who reported this. It wasn't to me- probably a CNA (certified nursing assistant) (add		having all the information. Staff members at the Alpha Home all have criminal background checks completed. Prior to employment the potential new hire shall all have their pre-employment file and checklist reviewed by human resource? New hire information and completed folders to be presented to quality assurance committee meeting. Corrective action plans completed on staff # 4, #5, # 6, #7 and employee # 8. This includes criminal background checks, employee checklists, and resident rights and abuse training. No staff begins orientation until signed checklist completed by manager reviewed by administrator and monitored by the quality assurance committee. Resident # 41 has been re- interviewed; the ISDPH has received a secondary follow up report with the staff person already being terminated. (Refer to F-225) Resident # 32 has therapy orders and is receiving therapy from qualified licensed therapist. Resident and or family member received notification on new therapy company. (Refer to F-311). Resident # 28 is receiving therapy and new therapy orders are in place. Resident and or family member notified of therapy. (Refer to F- 311) Resident # 34 therapy evaluated speech evaluation concluded. Conclusive report for resident abuse sent to ISDPH, care plan updated,	

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	period and space) A CNA reported it to me. I want to say towards the end of the shift. She said '(Resident #41 named) was down there complaining and he was mad and when he got up he was rough with him.' Me and the social service interviewed him. When an allegation. The person who is alleged is suspended immediately." The DON was asked if this CNA was suspended. She replied, "Yes, he was. If I am correct. Then the SSD and I talked to him and asked him what was going on and what had happened to him and that's when he told us he was turned around and transferred roughly in his chair. We reported it to (the Administrator named) the same day. We suspended him pending the outcome of the investigation...." The DON indicated the facility did not complete a thorough investigation to determine if the allegation of abuse was substantiated. She indicated the employee named in the allegation of abuse continued providing resident care until July 2013. The DON indicated the allegation of abuse had not been reported to the State agency. An undated policy, identified as current and titled "Alpha Home primary policy Abuse Prohibition" was		additional narrative from staff completing fully investigated allegation of abuse. Staff person #1, #4, # 5, #6, #7, # 8, Corrective action plans completed. Copies of criminal background check submitted during survey. This includes criminal background checks, employee checklists, and resident rights and abuse training. No staff begins orientation until signed checklist completed by manager reviewed by administrator and with monitoring by the quality assurance committee. Resident # 6 is no longer residing at the Alpha home. Hospice however to integrate their team and care plan communication with the Alpha home team. Hospice team and Alpha Home team have meet with scheduled in service, new agreement implemented staff trained on coordination of facility care plan and integration of hospice overall plan of care. There is no resident # A listed in the resident sample. However if a resident is in need of a bowel and bladder assessment it is care plan and reviewed with the quality assurance completed. Completed resident care plan updated with instructions to manage urine incontinence. Facility implementation of bladder program with the Quality assurance meeting on 10/14/13(F - 279) The wound care nurse completes wound care reports weekly along with the monthly	

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	provided by the Administrator on 9/12/2013 at 3:00 P.M. This policy indicated, "...It shall be the policy of Alpha Home to assure that all residents of this facility are free from ...physical... abuse... This primary abuse prohibition policy has 7 components. They are: 1. Screening 2. Training 3. Prevention 4. Identification 5. Investigation 6. Protection 7. Reporting/Response. It is the policy of Alpha Home of report, track, and monitor unusual occurrences in accordance with State law... ABUSE... (known and/or alleged).... Physical abuse.... Staff to resident abuse with or without injury.... It is the policy of Alpha Home to contact the ISDH (Indiana State Department of Health) ...within 24 hours. .... It is the policy of Alpha Home to implement the following procedures should any type of abuse or alleged abuse occur... immediately report to the administrator or his designee.... Ensuring the resident safety is most critical.... The Administrator or his designees in his absence are required to report the allegation to the Indiana State Department of Public Health.... If allegation of abuse are alleged against staff, the staff is removed from the schedule until the abuse investigation is concluded....		infection report. Policy and procedure implemented and training for staff to implement protocol. (F - 441) Infection control reports to be review by quality assurance committee and additional recommendations. The facility has implemented the new skilled nursing advanced beneficiary notice from the Medicare website. The letter sent out to families on 10/13/14 with notification of benefits and appeal rights. Other Residents with Potential to be affected by this finding will be identified by: All residents receiving therapy, notification of skilled nursing advanced beneficiary notice and the potential for abuse allegation had the potential to be affected by this finding; however, no other residents were affected. The communication is shared on the nursing units with the cuddle/ huddle meeting. . The Alpha Home has implemented the appropriate corrective action with suspension and or termination of staff for a noncompliance. The reports are documented and reviewed at the managers meeting and submission to the ISDPH for complete narrative and the conclusion of the investigation. The Alpha Home is currently submitting all reports to the Department of Health. The Alpha Home will continue to report in a prompt manner, to the regulatory agency, resident's family, and physician. These	

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	Procedure to report suspected abuse... Immediately contact the administrator or his designee...of any alleged abuse.... Notification to the ISDPH.... allegation [sic] to be investigated and documented including staff narratives when necessary...." 3.1-27(a)(1)		follow up reports will continue with prompt submission to the ISDPH via fax, and written communication to ISDPH. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Before hire checklist implement containing all information for a new hire implemented. Care planning with the hospice and Alpha home team implemented. Facility to submit pre and post investigation reports to ISDPH with narratives and conclusion to the reports. The interdisciplinary team reviews the new hire information daily, Medicare cut letters and therapy service submitted to families. IV. Corrective Actions will be monitored to Ensure Compliance by: Quality Assurance Recommendation team will review Pre employment hire lists, New and completed therapy orders, Medicare advanced skilled letters, Hospice intervention and care plans. All reports with audits with finding submitted to the Quality Assurance at its regular scheduled monthly meeting. This practice will be on going for the next three months. The Quality Assurance Committee will review and make recommendation for continuous quality improvements, after three months the committee will determine if additional recommendation is necessary. V. Completion Date: 09/17/13	

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F000225 SS=F	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 1. Based on interview and record	F000225	F225 Were other residents	10/16/2013

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	review, the facility failed to ensure allegations of abuse were immediately reported to the Administrator and/or State agency. The facility failed to ensure allegations of abuse were thoroughly investigated for 2 of 3 residents reviewed for allegations of abuse (Resident #41 and Resident #34). 2. Based on interview and record review, the facility failed to ensure criminal history checks were completed to ensure individuals were not employed who had been found guilty of abusing, neglecting, or mistreating residents by a court of law for 7 of 17 currently employed staff reviewed for pre-screening requirements. This deficient practice had the potential to affect 38 of 38 residents who resided in the facility. Findings include: 1(a). Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Resident #41 had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, a history of a stroke with left sided weakness, and seizures. A quarterly Minimum Data Set Assessment Tool (MDS) dated 7/1/13, indicated Resident #41 was		identified with potential to be affected by the deficiency? There are no other residents that have been identified to be affected by this deficiency. Potentially all residents could have been affected. All employees currently working identified in the 2567 have had criminal background checks completed. All employee files have been reviewed to assure that criminal background checks are present. What measures and systemic changes were put in place to assure deficient practice does not recur? The policy related to abuse has been re-in-serviced to assure a thorough understanding of the regulation including the reporting of unusual occurrences in a timely manner to the administrator. All staff has been in-serviced related to the policy. The Administrator is responsible for assuring that all allegations of abuse are thoroughly investigated and reported in a timely manner in accordance with the regulation. The abuse policy has been amended to include screening of potential employees. All department managers have been in-serviced related to assuring that criminal background checks are completed on all new hires. The Department Managers is responsible for assuring that this is completed appropriately. As a second review, the HR director will review all new hires to assure that the background checks have	

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	cognitively intact with a BIMS (brief interview mental status cognition assessment tool) score of 14., totally dependent on the assistance of one staff for locomotion, dressing, personal hygiene, bathing, transfers, and toileting. A record titled 'Care Plan Meeting Sign in Sheet" dated 5/30/2013, indicated staff present for the meeting included the DON, Administrator, Social Service Director, and Resident #41. This record indicated, "... Res (Resident) says sit on edge of bed, Lt (left) knee were buckle on his own. Aide grabbed et threw in w/c before breakfast. Says grabbed around under arms (bear hug) picked up from bed et threw in chair. Resident rushed to dining DR.... Had therapy/look at arm/shoulder. Res says this has happened more than once.... Allegation against employee-employee suspended...." During an interview on 9/10/2013 at 2:03 P.M., Resident #41 indicated a staff member had abused him. Resident #41 stated, "He is gone now. Three months ago. Don't remember his name. It was an aide. He picked me up and slung me around. He threw me in the chair. I told him I got a bad shoulder. He		been completed. Were any in-services/education provided to address deficient practice? All staff have been in-serviced on the abuse policy and proper protocol. All department managers have been in-serviced related to assuring that all new hires have criminal background checks completed on all new hires. Was a monitoring system implemented to ensure the deficient practice does not occur? An audit tool has been completed that reviews any unusual occurrences to assure that it was thoroughly investigated, protocol was followed, and it was reported properly. In addition, the tool will review 5 new hires (if applicable) to assure that they have criminal background checks in place. The Administrator, or designee, is responsible for the completion of the tools. These tools will be completed weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately. The facility will continue weekly monitoring if negative findings are identified as a result of the audit until compliance is reached. The tools will be reviewed at the regularly scheduled meetings with recommendations as needed based on the outcome of the audits. Were any policies developed or amended to address the deficient practice? The abuse policy has been amended to include screening of potential employees including	

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	picked me up by my bad shoulder. I told him to use the gait belt or put me on the lift. He (said he) didn't have to use the lift. He was superman. He did it twice. I had to report him. They chewed him out but he is gone because I wasn't the only one he was doing it to. I told the nurse and the DON (Director of Nursing). Takes awhile. He knew how to do the job right but he was in a hurry so he was just going to slam me around so he could go on to the next person. So did he do it to intentionally to hurt me or did he do it because he wasn't doing his job right. I would have to put a question mark at the end of that question." During an interview on 9/16/2013 at 2:30 P.M., with the Social Service Director (SSD), the DON, and the Administrator present, the following information was requested: 1) A list of all allegations of abuse for the last three months. 2) Any grievances specifically regarding Resident #41 and his allegation of abuse regarding a staff "throwing him in a chair." The Administrator indicated he did not think there had been any but he would look. During an interview on 9/18/2013 at 12:06 P.M., the DON indicated		criminal background checks. F- 225 INVESTIGATE/REPORT ALLEGATIONS INDIVIDUALS The Alpha Home policy is to not employ individuals who have been found guilty of abusing neglecting or mistreating residents by a court of law. Also to report allegation of mistreatment to State officials and state agency. Corrective Action related to this finding: Prior to being hired Alpha Home checklist is in place to prevent new staff from starting without having all the information. Staff members at the Alpha Home all have criminal background checks completed. Prior to employment the potential new hire shall all have their pre-employment file and checklist reviewed by human resource? New hire information and completed folders to be presented to quality assurance committee meeting. Corrective action plans completed on staff # 4, #5, # 6, #7 and employee # 8. This includes criminal background checks, employee checklists, and resident rights and abuse training. No staff begins orientation until signed checklist completed by manager reviewed by administrator and monitored by the quality assurance committee. Resident # 41 has been re- interviewed; the ISDPH has received a secondary follow up report with the staff person already being terminated. (Refer to F-225)	

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	Resident #41 complained about everyone. The DON stated, "First allegation I heard when he put him the chair. He was rough with him. I can't remember who reported this. It wasn't to me- probably a CNA (certified nursing assistant) (add period and space) A CNA reported it to me. I want to say towards the end of the shift. She said '(Resident #41 named) was down there complaining and he was mad and when he got up he was rough with him.' Me and the social service interviewed him. When an allegation. The person who is alleged is suspended immediately." The DON was asked if this CNA was suspended. She replied, "Yes, he was. If I am correct. Then the SSD and I talked to him and asked him what was going on and what had happened to him and that's when he told us he was turned around and transferred roughly in his chair. We reported it to (the Administrator named) the same day. We suspended him pending the outcome of the investigation...." The DON indicated the facility did not complete a thorough investigation to determine if the allegation of abuse was substantiated. She indicated the employee named in the allegation of abuse continued providing resident care until July 2013. The DON		Resident # 32 has therapy orders and is receiving therapy from qualified licensed therapist. Resident and or family member received notification on new therapy company. (Refer to F-311). Resident # 28 is receiving therapy and new therapy orders are in place. Resident and or family member notified of therapy. (Refer to F- 311) Resident # 34 therapy evaluated speech evaluation concluded. Conclusive report for resident abuse sent to ISDPH, care plan updated, additional narrative from staff completing fully investigated allegation of abuse. Staff person #1, #4, # 5, #6, #7, # 8, Corrective action plans completed. Copies of criminal background check submitted during survey. This includes criminal background checks, employee checklists, and resident rights and abuse training. No staff begins orientation until signed checklist completed by manager reviewed by administrator and with monitoring by the quality assurance committee. Resident # 6 is no longer residing at the Alpha home. Hospice however to integrate their team and care plan communication with the Alpha home team. Hospice team and Alpha Home team have meet with scheduled in service, new agreement implemented staff trained on coordination of facility care plan and integration of hospice overall plan of care.	

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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
	indicated the allegation of abuse had not been reported to the State agency according to State law. 1(b). Resident #34's record was reviewed on 9/16/13 at 10:15 A.M. Resident #34's diagnoses included, but were not limited to, depression, dementia, tachycardia, and arthritis. A document titled "Alpha Home Grievance and Complaint" dated 8/12/2013 indicated an allegation of abuse was reported by Resident #34. This document indicated, "Concern reported by (Resident #34 named), reported to Social Worker, Admin./DON. Date 8/12/2013... Resident initially reported incident to Admin, Social Service and D.O.N. She stated that an unknown person came into her room and severely beat her with the call-light cord. Investigation Report and Outcome: (Resident #34 named) was ask permission to be physically assessed and she gave permission. She was assessed from head to toe and no evidence of bruising or scarring noted. (Resident is fair skinned and any type or trauma to res. Skin would be easily detected. Residents daughter reported to Administrator next day that residents mother was in next room (deceased for 10 years)		There is no resident # A listed in the resident sample. However if a resident is in need of a bowel and bladder assessment it is care plan and reviewed with the quality assurance completed. Completed resident care plan updated with instructions to manage urine incontinence. Facility implementation of bladder program with the Quality assurance meeting on 10/14/13(F - 279) The wound care nurse completes wound care reports weekly along with the monthly infection report. Policy and procedure implemented and training for staff to implement protocol. (F - 441) Infection control reports to be review by quality assurance committee and additional recommendations. The facility has implemented the new skilled nursing advanced beneficiary notice from the Medicare website. The letter sent out to families on 10/13/14 with notification of benefits and appeal rights. Other Residents with Potential to be affected by this finding will be identified by: All residents receiving therapy, notification of skilled nursing advanced beneficiary notice and the potential for abuse allegation had the potential to be affected by this finding; however, no other residents were affected. The communication is shared on the nursing units with the cuddle/ huddle meeting. . The Alpha Home has implemented the	

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	daughter concerned about cognition. Staff also reported resident refusing care. MD notified Resident sent out for altered mental status...." During an interview on 9/18/2013 at 10:57 A.M., the Administrator was asked to provide the investigation conducted regarding the allegations of abuse reported by Resident #34. During an interview on 9/18/2013 at 1:49 P.M., with the Administrator and the DON present, the Administrator indicated the incident was reported to the Indiana State Department of Health. The Administrator indicated because the physical assessment completed on Resident #34 revealed no injuries there was not a need for further investigation. 2. Employee records were reviewed on 9/17/2013. Documentation was lacking which indicated criminal history checks had been completed for the following employees: 1) CNA (certified nursing assistant) #4 -hire date 8/28/2013. 2) CNA #5-hire date 6/26/2013. 3) CNA #6-hire date 7/26/2013. 4) CNA #7-hire date 8/19/13. 5) CNA #8-no hire date available. 6) House Keeper #1-hire date 8/2/2013. 7) Dietary Staff #1-hire date 8/22/13.		appropriate corrective action with suspension and or termination of staff for a noncompliance. The reports are documented and reviewed at the managers meeting and submission to the ISDPH for complete narrative and the conclusion of the investigation. The Alpha Home is currently submitting all reports to the Department of Health. The Alpha Home will continue to report in a prompt manner, to the regulatory agency, resident's family, and physician. These follow up reports will continue with prompt submission to the ISDPH via fax, and written communication to ISDPH. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Before hire checklist implement containing all information for a new hire implemented. Care planning with the hospice and Alpha home team implemented. Facility to submit pre and post investigation reports to ISDPH with narratives and conclusion to the reports. The interdisciplinary team reviews the new hire information daily, Medicare cut letters and therapy service submitted to families. IV. Corrective Actions will be monitored to Ensure Compliance by: Quality Assurance Recommendation team will review Pre employment hire lists, New and completed therapy orders, Medicare advanced	

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	During an interview on 9/18/2013 at 11:17 A.M., the DON stated, "The Business Office Manger used to do it. We don't have one now. I try to do my reference checks and put them on the application. I do at least two." The DON indicated medical records Employee #10 did the criminal history checks on prospective employees. During an interview on 9/18/2013 at 11:20 A.M., Employee #10 stated, "I have just been trying to help out with employee files. It is not in my job description. I have been helping for two or three months. I have a list of employees. They have to get their own criminal history checks. I make sure I put it in their file. If file is not complete I tell the actual person I need such and such." Staff #10 was asked if she reported to the DON and/or the Administrator if the potential employee did not provide the criminal history check. Staff #10 stated, "No, I can't say they know. (The DON named) wouldn't know if they didn't have it because I don't tell them we are missing it..." During an interview on 9/18/2013 at 11:40 A.M., with the DON, and the Administrator present, Employee #10 indicated she did not inform the DON		skilled letters, Hospice intervention and care plans. All reports with audits with finding submitted to the Quality Assurance at its regular scheduled monthly meeting. This practice will be on going for the next three months. The Quality Assurance Committee will review and make recommendation for continuous quality improvements, after three months the committee will determine if additional recommendation is necessary. V. Completion Date: 09/17/13	

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	or the Administrator when an employee had not provided a criminal history check. Employee #10 stated, "I told you I did not." The Administrator was asked what the system was to ensure criminal history checks were completed on prospective employees. The Administrator stated, "There is a check list." The DON was asked if she checked to see if criminal history checks were completed prior to hiring and scheduling staff to work with residents. The DON replied, "I don't do the scheduling. I am not trying to pass the buck. Sometimes I check. Sometimes I don't. At this time documentation of the following current employees criminal history checks were requested: 1) CNA (certified nursing assistant) #4-hire date 8/28/2013. 2) CNA #5-hire date 6/26/2013. 3) CNA #6-hire date 7/26/2013. 4) CNA #7-hire date 8/19/13. 5) CNA #8-no hire date available. 6) House Keeper #1-hire date 8/2/2013. 7) Dietary Staff #1-hire date 8/22/13. During an interview on 9/18/2013 at 12:17 P.M., the DON indicated she was aware employees were required to have criminal history checks prior to working with residents. The DON			

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	indicated the facility did not have criminal history checks for the following employees: 1) CNA (certified nursing assistant) #4-hire date 8/28/2013. 2) CNA #5-hire date 6/26/2013. 3) CNA #6-hire date 7/26/2013. 4) CNA #7-hire date 8/19/13. 5) CNA #8-no hire date available. 6) House Keeper #1-hire date 8/2/2013. 7) Dietary Staff #1-hire date 8/22/13. An undated policy identified as current and titled "Alpha Home Primary Policy Abuse Prohibition" was provided by the Administrator on 9/12/2013 at 3:00 P.M. This policy indicated, "...It shall be the policy of Alpha Home to assure that all residents of this facility are free from ...physical... abuse... This primary abuse prohibition policy has 7 components. They are: 1. Screening 2. Training 3. Prevention 4. Identification 5. Investigation 6. Protection 7. Reporting/Response. It is the policy of Alpha Home of report, track, and monitor unusual occurrences in accordance with State law... ABUSE... (known and/or alleged).... Physical abuse.... Staff to resident abuse with or without injury.... It is the policy of Alpha Home to contact the ISDH (Indiana State Department of Health) ...within			

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	24 hours. .... It is the policy of Alpha Home to implement the following procedures should any type of abuse or alleged abuse occur... immediately report to the administrator or his designee.... Ensuring the resident safety is most critical.... The Administrator or his designee in his absence is required to report the allegation to the Indiana State Department of Public Health.... If allegations of abuse are alleged against staff, the staff is removed from the schedule until the abuse investigation is concluded.... Procedure to report suspected abuse... Immediately contact the administrator or his designee...of any alleged abuse.... Notification to the ISDPH.... allegation [sic] to be investigated and documented including staff narratives when necessary...." The facility's current abuse policy failed to contain procedures to screen prospective employees to ensure employees who had been found guilty of abusing, neglecting, or mistreating residents by a court of law; or had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.			

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	3.1-28(a) 3.1-28)(b)(1) 3-1-28(b)c) 3-1-28(b)(d)			

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F000226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. Based on interview and record review, the facility failed to develop and/or implement its policies and procedures to ensure allegations of abuse were immediately reported to the Administrator and/or State agency. The facility failed to ensure allegations of abuse were thoroughly investigated for 2 of 3 residents reviewed for allegations of abuse (Resident #41 and Resident #34). 2. Based on interview and record review, the facility failed to develop and/or implement its policies and procedures to ensure criminal history checks were completed to ensure individuals were not employed who had been found guilty of abusing, neglecting, or mistreating residents by a court of law for 7 of 17 currently employed staff reviewed for pre-screening requirements. This deficient practice had the potential to affect 38 of 38 residents who resided in the facility. Findings include:	F000226	F226 Were other residents identified with potential to be affected by the deficiency? There are no other residents that have been identified to be affected by this deficiency. Potentially all residents could have been affected. All employees currently working identified in the 2567 have had criminal background checks completed. All employee files have been reviewed to assure that criminal background checks are present. What measures and systemic changes were put in place to assure deficient practice does not recur? The policy related to abuse has been re-in-serviced to assure a thorough understanding of the regulation including the reporting of unusual occurrences in a timely manner to the administrator. All staff has been in-serviced related to the policy. The Administrator is responsible for assuring that all allegations of abuse are thoroughly investigated and reported in a timely manner in accordance with the regulation. The abuse policy has been amended to include screening of potential employees. All department managers have been	10/16/2013

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	1(a). Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Resident #41 had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, a history of a stroke with left sided weakness, and seizures. A quarterly Minimum Data Set Assessment Tool (MDS) dated 7/1/13, indicated Resident #41 was cognitively intact with a BIMS (brief interview mental status cognition assessment tool) score of 14., totally dependent on the assistance of one staff for locomotion, dressing, personal hygiene, bathing, transfers, and toileting. A record titled 'Care Plan Meeting Sign in Sheet" dated 5/30/2013, indicated staff present for the meeting included the DON, Administrator, Social Service Director, and Resident #41. This record indicated, "... Res (Resident) says sit on edge of bed, Lt (left) knee were buckle on his own. Aide grabbed et threw in w/c before breakfast. Says grabbed around under arms (bear hug) picked up from bed et threw in chair. Resident rushed to dining DR.... Had therapy/look at arm/shoulder. Res says this has happened more than once.... Allegation against		in-serviced related to assuring that criminal background checks are completed on all new hires. The Department Managers is responsible for assuring that this is completed appropriately. As a second review, the HR director will review all new hires to assure that the background checks have been completed. Were any in-services/education provided to address deficient practice? All staff has been in-serviced on the abuse policy and proper protocol. All department managers have been in-serviced related to assuring that all new hires have criminal background checks completed on all new hires. Was a monitoring system implemented to ensure the deficient practice does not occur? An audit tool has been completed that reviews any unusual occurrences to assure that it was thoroughly investigated, protocol was followed, and it was reported properly. In addition, the tool will review 5 new hires (if applicable) to assure that they have criminal background checks in place. The administrator, or designee, is responsible for the completion of the tools. These tools will be completed weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately. The facility will continue weekly monitoring if negative findings are identified as a result of the audit until compliance is reached. The tools will be reviewed at the	

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	employee-employee suspended...." During an interview on 9/10/2013 at 2:03 P.M., Resident #41 indicated a staff member had abused him. Resident #41 stated, "He is gone now. Three months ago. Don't remember his name. It was an aide. He picked me up and slung me around. He threw me in the chair. I told him I got a bad shoulder. He picked me up by my bad shoulder. I told him to use the gait belt or put me on the lift. He (said he) didn't have to use the lift. He was superman. He did it twice. I had to report him. They chewed him out but he is gone because I wasn't the only one he was doing it to. I told the nurse and the DON (Director of Nursing). Takes awhile. He knew how to do the job right but he was in a hurry so he was just going to slam me around so he could go on to the next person. So did he do it to intentionally to hurt me or did he do it because he wasn't doing his job right. I would have to put a question mark at the end of that question." During an interview on 9/16/2013 at 2:30 P.M., with the Social Service Director (SSD), the DON, and the Administrator present, the following information was requested: 1) A list		regularly scheduled meetings with recommendations as needed based on the outcome of the audits. Were any policies developed or amended to address the deficient practice? The abuse policy has been amended to include screening of potential employees including criminal background checks. F 226– DEVELOP/IMPLEMENTABUSE/ NEGLECT.ETC POLICIES Corrective Action Taken Related to this Finding: Staff members at the Alpha Home all have criminal background checks completed. Prior to employment the potential new hire shall all have their pre-employment file and checklist reviewed by human resource, New hire information and completed folders to be presented to quality assurance committee meeting. Corrective action plans completed on staff # 4, #5, # 6, #7 and employee # 8. This includes criminal background checks, employee checklists, and resident rights and abuse training. No staff begins orientation until signed checklist completed by manager reviewed by administrator and monitored by the quality assurance committee. Employee involved in the allegation terminated. Facility director to fully investigate allegation with immediate suspension and reporting to the state agencies. II. Other Residents with Potential	

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	of all allegations of abuse for the last three months. 2) Any grievances specifically regarding Resident #41 and his allegation of abuse regarding a staff "throwing him in a chair." The Administrator indicated he did not think there had been any but he would look. During an interview on 9/18/2013 at 12:06 P.M., the DON indicated Resident #41 complained about everyone. The DON stated, "First allegation I heard when he put him the chair. He was rough with him. I can't remember who reported this. It wasn't to me- probably a CNA (certified nursing assistant) (add period and space) A CNA reported it to me. I want to say towards the end of the shift. She said '(Resident #41 named) was down there complaining and he was mad and when he got up he was rough with him.' Me and the social service interviewed him. When an allegation. The person who is alleged is suspended immediately." The DON was asked if this CNA was suspended. She replied, "Yes, he was. If I am correct. Then the SSD and I talked to him and asked him what was going on and what had happened to him and that's when he told us he was turned around and transferred roughly in his chair. We		to be affected by this finding will be identified by: All residents who reside at the Alpha Home have the potential to be affected are affected by this finding however no other residents were defined to be affected. Resident interviews, additional staff training Resident council meeting, family council, and satisfaction surveys are used to address potential residents affected. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Abuse policy amended to include new hire new hire requirement background history check, to rule out potential new hires who have been convicted of abusing mistreatment or neglect of an employee. No new hires are added to the schedule without the checklist being completed and the signature approval of the departmental manager and administrator. The Alpha Home corrective action plan to ensure compliance shall be accomplished with the interdisciplinary reviewing the audit and ensuring 100% compliance. Noncompliance re submitted to the Quality Assurance Committee scheduled meeting monthly. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by. The checklist	

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	reported it to (the Administrator named) the same day. We suspended him pending the outcome of the investigation...." The DON indicated the facility did not complete a thorough investigation to determine if the allegation of abuse was substantiated. She indicated the employee named in the allegation of abuse continued providing resident care until July 2013. The DON indicated the allegation of abuse had not been reported to the State agency according to State law. 1(b). Resident #34's record was reviewed on 9/16/13 at 10:15 A.M. Resident #34's diagnoses included, but were not limited to, depression, dementia, tachycardia, and arthritis. A document titled "Alpha Home Grievance and Complaint" dated 8/12/2013 indicated an allegation of abuse was reported by Resident #34. This document indicated, "Concern reported by (Resident #34 named), reported to Social Worker, Admin./DON. Date 8/12/2013... Resident initially reported incident to Admin, Social Service and D.O.N. She stated that an unknown person came into her room and severely beat her with the call-light cord. Investigation Report and Outcome:		completion by the department manager, second review by the human resource completion signature by the department manager and the administrator. Noncompliance will result in suspension and or termination according to the handbook. The audited checklist sheets to be submitted to the Quality Assurance team for review and additional recommendations. V. Corrected Action Completion Date 10/16/13	

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	(Resident #34 named) was ask permission to be physically assessed and she gave permission. She was assessed from head to toe and no evidence of bruising or scarring noted. (Resident is fair skinned and any type or trauma to res. Skin would be easily detected. Residents daughter reported to Administrator next day that residents mother was in next room (deceased for 10 years) daughter concerned about cognition. Staff also reported resident refusing care. MD notified Resident sent out for altered mental status...." During an interview on 9/18/2013 at 10:57 A.M., the Administrator was asked to provide the investigation conducted regarding the allegations of abuse reported by Resident #34. During an interview on 9/18/2013 at 1:49 P.M., with the Administrator and the DON present, the Administrator indicated the incident was reported to the Indiana State Department of Health. The Administrator indicated because the physical assessment completed on Resident #34 revealed no injuries there was not a need for further investigation. 2. Employee records were reviewed on 9/17/2013. Documentation was			

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	lacking which indicated criminal history checks had been completed for the following employees: 1) CNA (certified nursing assistant) #4 -hire date 8/28/2013. 2) CNA #5-hire date 6/26/2013. 3) CNA #6-hire date 7/26/2013. 4) CNA #7-hire date 8/19/13. 5) CNA #8-no hire date available. 6) House Keeper #1-hire date 8/2/2013. 7) Dietary Staff #1-hire date 8/22/13. During an interview on 9/18/2013 at 11:17 A.M., the DON stated, "The Business Office Manger used to do it. We don't have one now. I try to do my reference checks and put them on the application. I do at least two." The DON indicated medical records Employee #10 did the criminal history checks on prospective employees. During an interview on 9/18/2013 at 11:20 A.M., Employee #10 stated, "I have just been trying to help out with employee files. It is not in my job description. I have been helping for two or three months. I have a list of employees. They have to get their own criminal history checks. I make sure I put it in their file. If file is not complete I tell the actual person I need such and such." Staff #10 was asked if she reported to the DON and/or the Administrator if the			

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	potential employee did not provide the criminal history check. Staff #10 stated, "No, I can't say they know. (The DON named) wouldn't know if they didn't have it because I don't tell them we are missing it..." During an interview on 9/18/2013 at 11:40 A.M., with the DON, and the Administrator present, Employee #10 indicated she did not inform the DON or the Administrator when an employee had not provided a criminal history check. Employee #10 stated, "I told you I did not." The Administrator was asked what the system was to ensure criminal history checks were completed on prospective employees. The Administrator stated, "There is a check list." The DON was asked if she checked to see if criminal history checks were completed prior to hiring and scheduling staff to work with residents. The DON replied, "I don't do the scheduling. I am not trying to pass the buck. Sometimes I check. Sometimes I don't. At this time documentation of the following current employees criminal history checks were requested: 1) CNA (certified nursing assistant) #4-hire date 8/28/2013. 2) CNA #5-hire date 6/26/2013. 3) CNA			

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	#6-hire date 7/26/2013. 4) CNA #7-hire date 8/19/13. 5) CNA #8-no hire date available. 6) House Keeper #1-hire date 8/2/2013. 7) Dietary Staff #1-hire date 8/22/13. During an interview on 9/18/2013 at 12:17 P.M., the DON indicated she was aware employees were required to have criminal history checks prior to working with residents. The DON indicated the facility did not have criminal history checks for the following employees: 1) CNA (certified nursing assistant) #4-hire date 8/28/2013. 2) CNA #5-hire date 6/26/2013. 3) CNA #6-hire date 7/26/2013. 4) CNA #7-hire date 8/19/13. 5) CNA #8-no hire date available. 6) House Keeper #1-hire date 8/2/2013. 7) Dietary Staff #1-hire date 8/22/13. An undated policy identified as current and titled "Alpha Home Primary Policy Abuse Prohibition" was provided by the Administrator on 9/12/2013 at 3:00 P.M. This policy indicated, "...It shall be the policy of Alpha Home to assure that all residents of this facility are free from ...physical... abuse... This primary abuse prohibition policy has 7 components. They are: 1. Screening 2. Training 3. Prevention			

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	4. Identification 5. Investigation 6. Protection 7. Reporting/Response. It is the policy of Alpha Home of report, track, and monitor unusual occurrences in accordance with State law... ABUSE... (known and/or alleged).... Physical abuse.... Staff to resident abuse with or without injury.... It is the policy of Alpha Home to contact the ISDH (Indiana State Department of Health) ...within 24 hours. .... It is the policy of Alpha Home to implement the following procedures should any type of abuse or alleged abuse occur... immediately report to the administrator or his designee.... Ensuring the resident safety is most critical.... The Administrator or his designee in his absence is required to report the allegation to the Indiana State Department of Public Health.... If allegations of abuse are alleged against staff, the staff is removed from the schedule until the abuse investigation is concluded.... Procedure to report suspected abuse... Immediately contact the administrator or his designee...of any alleged abuse.... Notification to the ISDPH.... allegation [sic] to be investigated and documented including staff narratives when necessary...."			

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	The facility's current abuse policy failed to contain procedures to screen prospective employees to ensure employees who had been found guilty of abusing, neglecting, or mistreating residents by a court of law; or had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. 3.1-28(a) 3.1-28)(b)(1) 3-1-28(b)c) 3-1-28(b)(d)			

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F000247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure residents were informed of room changes for 2 of 15 residents interviewed for notification of room change. (Resident #33 and #41) Findings include: 1. During an interview on 9/10/13 at 10:05 a.m., Resident #33 indicated he was moved to another room without a notice. 2. During an interview on 9/10/13 at 2:25 p.m., Resident #41 indicated "they just came and moved me down there for awhile and the phone and stuff didn't work down there so they came and moved me back here." During an interview on 9/13/13 at 9:20 A.M., SSD (Social Service Director) indicated there was a form to fill out and it was placed in the resident's chart. The SSD indicated approval of room change or roommate change would be done over the phone and the resident/family did have a right to	F000247	F247 Were other residents identified with potential to be affected by the deficiency? There were no additional residents identified to be affected by this deficiency. What measures and systemic changes were put in place to assure deficient practice does not recur? The interdisciplinary team has been in-serviced related to residents' right to notice before a room/roommate change. The IDT team will be the personnel determining if a resident room/roommate change may need to occur. If the determination is made that a room/roommate change may need to occur, Social Services (part of IDT) will discuss with resident/family member to assure that proper notice is provided to the resident/family in accordance with the regulation. Were any in-services/education provided to address deficient practice? The IDT team has been in-serviced related to protocol. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents (if applicable) who have had a room/roommate change. This form will be completed	10/16/2013

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	refuse. During an interview on 9/13/13 at 10:26 A.M., the SSD indicated Resident #33 was moved because of his own personal safety and she was not aware nor involved with the transfer. The SSD indicated there was not a form or any documentation of a room change found for resident #33. There was not a social service note indicating the resident had received a notice of a room change. 3.1-5(b)(1)		weekly x3, monthly x3, and then quarterly x3. The Social Services Director, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current policy was re-in-serviced. F 247– RIGHT TO NOTICE BEFORE ROOM ROOMATE CHANGE It is the policy of the Alpha Home to ensure a resident receive notice before the resident's or roommate is changed. Corrective Action Taken Related to this Finding: Resident #33 and Resident # 41 have now been notified of the reason for roommate change. The Alpha Home prior to any changing of residents shall have the residents receive correct notification prior to the room change. The resident shall receive notification, the family member the physician. There will be a transfer notification form completed as well as follow up documentation by the Social Service department and nurse notes acknowledging the move. At the morning managers meeting the resident transfer form and chart is review to ensure the	

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			transfer was completed correctly for the roommate and the resident. II. Other Residents with Potential to be affected by this finding will be identified by: All other residents having received transfer notices have the potential to be affected by this finding. However, after review of the charts no other residents were affected by these findings. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Residents transfer audit form completed. Audits structured to assist with completion of transfer information for residents and families The audit sheets, and resident updates are communicated to the staff. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by the Transfer audits. Presentation to the managers meeting and monitoring input from the quality assurance committee. These daily audit sheets completed by the social service nurses, and reviewed by the interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee	

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			at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. V. Corrected Action Completion Date 10/16/13	

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F000248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Based on observation and interview, the facility failed to ensure activities were provided to needs of residents during 3 of 7 days of the survey. Findings include: On 9/9/13 at 10:45 a.m., observed the activity room with 10 residents in the activity room not being engaged with activities. One resident was asleep with her head on the table and the others were sleeping or looking around not paying attention to the TV being on. On 9/10/13 at 11:00 a.m., observed the activity assistant walking in the TV lounge and not engaging residents with activities. There were 9 residents in the room. On 9/13/13 at 10:30 a.m., four residents was observed sitting in a room. The activity assistant was observed at the end of the table reading and not engaging residents in	F000248	F248 Were other residents identified with potential to be affected by the deficiency? There were no other residents identified to be affected by this deficient practice What measures and systemic changes were put in place to assure deficient practice does not recur? The facility has hired a Certified Activity Director to assure that are activity programming is appropriate for each of our residents. The Activity Director has been in-serviced related to encouraging participation in the activity programming and assuring that resident's activity needs are met. Were any in-services/education provided to address deficient practice? The new Certified Activity Director has been in-serviced related to activity programming and participation. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents related to activity programming and participation. This form will be completed weekly x3, monthly x3, and then quarterly x3. The	10/16/2013

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	activities. During an interview on 9/13/13 at 9:45 a.m., the assistant indicated his background was social service, he did not have any training with activities and he helped out in the facility where ever he was needed. The activity assistant indicated he had been hired for this position a few months ago. The activity assistant indicated he was waiting for formal training by the company. 3.1-33(a)		Activity Director, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current policy has been in-serviced F 248– ACTIVITIES MEET INTRESTS/NEEDS OF EACH RESIDENT It is the policy of the Alpha Home to provide ongoing activities that meet the needs of the resident in accordance with the comprehensive assessment and within best interest of the resident's physical, mental, and psychosocial needs. Corrective Action Taken Related to this Finding: The Alpha Home has identified and hired a certified Activity Director to manage the activity department. Activity assessment to be completed with identified activities developed to meet the resident needs. II. Other Residents with Potential to be affected by this finding will be identified by: All other residents having the potential to be affected by the finding had their assessment completed and their activity program modified to include meaningful activities. Volunteer and Volunteer groups	

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			will assist in the development and participation of residents in the activity program. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Retain the services of a certified activity director for the residents of the Alpha Home. Reassessment and interview with residents and family for special preference with activities of interest to the residents. Monthly review with resident attendance and participation for measuring the resident's satisfaction in activities. The customer satisfaction surveys allow the resident with the family members to rate the activity program for improvement. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by resident "s and families customer satisfaction surveys. The interdisciplinary team and resident's families to participate in care conference. This monitoring audit record will be presented each month for the next three months with recommendation from quality assurance committee. V. Corrected Action Completion Date 10/16/13	

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F000249 SS=D	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.			
	Based on observation, record review and interview, the facility failed to ensure activities were directed by a qualified professional during 3 of 7 days of the survey. Findings include: On 9/9/13 at 10:45 a.m., observed the activity room with 10 residents in the activity room not being engaged with activities. One resident was asleep with her head on the table and the others were sleeping or looking around not paying attention to the TV being on. On 9/10/13 at 11:00 a.m., observed	F000249	F 249– QUALIFICATION OF ACTIVITY PROFESSIONAL IT is a policy of the Alpha Home to have activities directed by certified activity director. The department manager to provide ongoing activities that meet the needs of the resident in accordance with the comprehensive assessment and within best interest of the resident's physical, mental, and psychosocial needs. Corrective Action Taken Related to this Finding: The Alpha Home hired a certified activity director. Activity assessment to be completed with identified activities developed to meet the resident needs. II. Other Residents with Potential to be affected by this finding will be identified by: All other residents	10/16/2013

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	the activity assistant walking in the TV lounge and not engaging residents with activities. There were 9 residents in the room. On 9/13/13 at 10:30 a.m., four residents was observed sitting in a room. The activity assistant was observed at the end of the table reading and not engaging residents in activities. During an interview on 9/13/13 at 9:45 a.m., the assistant indicated his background was social service, he did not have any training with activities and he helped out in the facility where ever he was needed. The activity assistant indicated he had been hired for this position a few months ago. The activity assistant indicated he was waiting for formal training by the company. A job description was provided on 9/17/13 at 12:40 p.m. The position requirements indicated, "...the Activity Director be one of the following: (1) a recreation therapist, (2) a licensed occupational therapist or licensed occupational therapy assistance, or (3) a person with a minimum of a high school diploma or equivalent who has completed the activity director course approved by the Indiana State		having the potential to be affected by the finding had their care plans review with the internal audit. 100 percent of the care plans audits have been completed. The weekly monitoring will continue with the unit manager and the director of nurses. The unit charge nurse will comply by adding any new orders, significant changes, or other pertinent information to the twenty hour report, for communication and inclusion in the care plan. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Retain the services of a certified activity director for the residents of the Alpha Home. Reassessment and interview with residents and family for special preference with activities of interest to the residents. Monthly review with resident attendance and participation for measuring the resident's satisfaction in activities. The customer satisfaction surveys allow the resident with the family members to rate the activity program for improvement. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by resident "s and families customer satisfaction surveys. The interdisciplinary team and resident's families to participate in care conference. This monitoring audit record will	

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	Department of Health. The Activity Director must also have two years of experience working in a geriatric setting, with a preference for a person with that experience on a full-time basis in a social or recreational program in a long-term care facility or other program serving geriatric adults." During an interview on 9/18/13 at 12:00 p.m., the DoN (Director of Nursing) indicated the company had been searching for a Activity Director for approximately one year. 3.1-33(e)(1) 3.1-33(e)(2) 3.1-33(e)(3) 3.1-33(e)(4)		be presented each month for the next three months with recommendation from quality assurance committee. V. Corrected Action Completion Date 10/16/13	

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ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F000279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed to ensure care plans were developed with measurable goals in relation to hospice, rehabilitation, and unnecessary medications for 2 out 23 residents reviewed for care plans. (Resident #A and #6) Findings include: 1. Resident #6's record was reviewed on 9/13/13 at 10:50 a.m. Resident #6's diagnoses included but were not limited to, end stage dementia.	F000279	F279 Were other residents identified with potential to be affected by the deficiency? All care plans were reviewed. There were no other residents identified to be affected by this deficiency. What measures and systemic changes were put in place to assure deficient practice does not recur? The MDS/Care Plan Coordinator has been in-serviced related to assuring that care plans accurately reflect the resident's current condition and the goals being measurable. The IDT team will meet each business morning and review the 24 hour report for any incidents, changes of	10/16/2013

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	Resident #6 was admitted to hospice on 3/26/13. A care plan dated 3/26/13, indicated hospice services secondary to end stage dementia. Interventions included admit to [Name of Hospice Company], the nurse and CNA to visit per their schedule and consult with hospice for change in condition. The care plan failed to indicate coordination of care and specific interventions between the facility and hospice services. An interview with the MDS (Minimum Data Set) Assessment Coordinator on 9/17/13 at 9:50 a.m., indicated she developed care plans during care plan meetings and when she received orders. A Hospice and Nursing Facility Service Agreement dated 11/08, indicated "When a resident of Nursing Facility is admitted to Hospice Program, Nursing Facility will immediately provide Hospice with a copy of Nursing Facility's current Plan of Care for Hospice Patient. Hospice will immediately provide Nursing Facility with a copy of the initial and subsequent Hospice Plan of Care for each Hospice patient. Nursing Facility will immediately notify		condition, and the physicians' orders for each resident. At this time, the information will be reviewed and the MDS/Care Plan Coordinator will update the plan of care related to any needed changes and include measurable goals. In addition, the IDT will work with any outside services such as Hospice to assure that the plan of care is appropriate and inclusive of the necessary services with measurable goals. Were any in-services/education provided to address deficient practice? The MDS/Care Plan Coordinator has been in-serviced related to assuring that the plan of care accurately reflects the resident's condition and that the goals are measurable. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents related to appropriate care planning and measurability of goals. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The MDS/Care Plan Coordinator, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies	

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	Hospice when a Hospice patient experiences a change in condition that warrants a change in Nursing Facility's Plan of Care for Hospice patient. A copy of the revised Plan of Care will be provided to the Hospice. Hospice will immediately notify Nursing Facility when a Hospice Patient experiences a change in condition that warrants a change in Hospice Patient's Plan of Care. A copy of the revised Hospice plan of Care will be provided to Nursing Facility." 2. Resident #A's record was reviewed on 9/11/13 at 2:10 p.m. Resident #A's diagnoses included, but were not limited to, CVA (stroke) and dementia. A Comprehensive Admission MDS (Minimum Data Set) Assessment dated 2/12/13, indicated the resident was frequently incontinent of urine (greater than 7 incontinent episodes, but at least one continent episode, in a week). The MDS indicated the resident was not on a toileting program to manage the resident's urinary incontinence. A Quarterly MDS Assessment dated 5/7/13, indicated the resident was always incontinent. The MDS		developed or amended to address the deficient practice? The current facility policy was appropriate and utilized for the in-service training F279 Were other residents identified with potential to be affected by the deficiency? All care plans were reviewed. There were no other residents identified to be affected by this deficiency. What measures and systemic changes were put in place to assure deficient practice does not recur? The MDS/Care Plan Coordinator has been in-serviced related to assuring that care plans accurately reflect the resident's current condition and the goals being measurable. The IDT team will meet each business morning and review the 24 hour report for any incidents, changes of condition, and the physicians' orders for each resident. At this time, the information will be reviewed and the MDS/Care Plan Coordinator will update the plan of care related to any needed changes and include measurable goals. In addition, the IDT will work with any outside services such as Hospice to assure that the plan of care is appropriate and inclusive of the necessary services with measurable goals. Were any in-services/education provided to address deficient practice? The MDS/Care Plan Coordinator has been in-serviced related to assuring that the plan of care accurately reflects the	

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	indicated the resident was not on a bladder program. A Quarterly MDS Assessment dated 8/1/13, indicated the resident was always incontinent. The MDS indicated the resident was not on a bladder program. A care plan for a toileting schedule to manage Resident #A's incontinence was not developed. An interview with the MDS Coordinator on 9/17/13 at 9:50 a.m., indicated she developed care plans during care plan meetings and when she received orders. A policy for Bowel and Bladder Evaluation and Retraining [undated], was provided by the DoN on 9/16/13 at 9:30 a.m. The policy indicated "It is the policy of this facility to improve or maintain the residents level of bowel and bladder. Complete the evaluation for bowel and bladder retraining within 7 days. Use the gathered data to determine if the resident has retraining potential. Develop a care plan and program specific the [sic] each resident and facilitate as indicated." This Federal Tag relates to complaint		resident's condition and that the goals are measurable. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents related to appropriate care planning and measurability of goals. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The MDS/Care Plan Coordinator, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy was appropriate and utilized for the in-service training F 279–DEVELOP COMPREHENSIVE CARE PLANS. IT IS THE POLICY OF THIS FACILITY TO DEVELOP COMPREHENSIVE CARE PLANS FOR EACH WITH MEASURABLE GOALS IN RELATION TO HOSPICE, REHABILITATION AND UNNECESSARY MEDS B Corrective Action Taken Related to this Finding: Resident A has transferred from this facility. Resident #6 is no longer a	

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	number IN00133532. 3.1-35(a)		resident at this facility. An audit of the facility residents was done to determine those in need of these care plan adjustment . II. Other Residents with Potential to be affected by this finding will be identified by: All other residents having the potential to be affected by the finding had their care plans review with the internal audit. All new resident will have their initial bowel and bladder assessment completed by the charge nurse and the information communicated to the MDS coordinator. An individual toileting plan will be developed to improve or maintain bladder function for each resident and evaluation of the progress documented and reported to the DON. Chargenurse will comply by adding any new orders, significant changes, or other pertinent information to the twenty hour report, for communication and inclusion in the care plan. Upon notification of the beginning of hospice services the charge nurse and MDS will communicate with the hospice nurse to develop a revised plan of care for the individual. All information from pharmacy consultant regarding unnecessary meds will be immediately addressed and reported to the attending physician. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All Care Plans will additionally address	

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			new physician orders, significant, changes , updated progress noted from service provided and contributing information that address the resident care. . The audit sheets, and resident updates are communicated to the staff. Communication with hospice services will occur with each new resident within 24 hours or admission to the services. An inservice will be provided by hospice to educate staff on the policies and procedures relevant to this facility. The restorative aide will remain off the schedule for direct floor care in order to provide continuous rehabilitative services. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by. The interdisciplinary each week to conduct correct action review of the audits. These daily audit sheets completed by the nurses, and reviewed by the interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the	

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			next three months with recommendation from the members from the quality assurance committee. V. Corrected Action Completion Date *10-16-13	

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F000280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure care plans were revised in relation to activities, dental, nutrition, urinary incontinence, unnecessary medications and vision for 5 of 23 residents reviewed for care plans. (Resident #1, #6, #26, #34 and #52) Findings include: 1. Resident #6's record was reviewed on 9/13/13 at 10:50 a.m. Resident #6's diagnosis included, but were not limited to, end stage dementia. Activity MDS Supportive	F000280	F309 Were other residents identified with potential to be affected by the deficiency? All residents have been reviewed related to positioning and assistive devices and no other residents were identified to be affected by this deficiency. What measures and systemic changes were put in place to assure deficient practice does not recur? All nursing staff has been in-serviced related to proper positioning and assistive devices related to the residents. The in-service included identifying residents that are not positioned properly during daily care and observation. Nursing staff has also been trained to assure that if	10/16/2013

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	Documentation Tool dated 7/5/12, indicated the resident "attended small groups daily - usually passive. Likes to attend musical and church groups most days too, but is passive. Likes sensory stimulation activities. Resident's 1:1 activity program was d/c (discontinued) on 7/2/12, due to attends both small and large groups." A care plan updated on 4/4/12, indicated the resident has a diagnosis of dementia. The interventions indicated on the date of 7/1/04, "remind resident of meal and group activity times as needed and encourage attendance for socialization and mental stimulation, praise resident when she spends time out of her room, enc resident to allow staff to help her." On 6/30/04, "to maintain a routine schedule, provide resident with cues and reminders to assist resident with recall and decision making." On 4/4/12, "to consult with hospice services as needed and undated, Cog (cognitive) & (and) sensory enrichment group for mental and sensory stimulation." A care plan updated on 4/4/12, indicated the resident had a diagnosis of dementia, needed reminders and assistance to activity programs. The interventions indicated on 11/24/08,		any resident is identified as have positioning issues that they are to be addressed immediately with interventions implemented as appropriate. The Director of Nursing, or designee, will be making rounds several times throughout the day to assure that residents are positioned appropriately. Were any in-services/education provided to address deficient practice? All nursing staff was in-serviced related to positioning/assistive devices for residents Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents related to assuring proper use of assistive devices and positioning of residents. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy was utilized for re-training. F279 Were other residents identified with potential to be affected by	

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	"remind and assist resident to activity programs, include resident in cooking, classes, reminiscing, bowling, crafts, continue to enc (encourage) socialization and assist resident in activities as needed. On 4/5/12, "for Sensory Enrichment group 2-3x/wk (times per week), encourage activities she prefers such as church, 1:1 visit from volunteer, sitting outdoors as weather permits and encourage simple choices as her ability allows." A care plan updated on 4/4/12, indicated the resident does not interact with other residents. The interventions indicated on 2/17/09, "activities will sit resident beside resident who will talk to {name of resident}." There was lack of documentation to indicate the care plans had been updated. A Social Service MDS (Minimum Data Set) Assessment Supportive Documentation note dated 6/7/13, indicated the resident had minimal difficulty hearing, no speech, sometimes understand-responds adequately to simple, direct communication only, impaired-sees large print, but not regular print but wears no corrective lenses. An interview with the Activity		the deficiency? All care plans were reviewed. There were no other residents identified to be affected by this deficiency. What measures and systemic changes were put in place to assure deficient practice does not recur? The MDS/Care Plan Coordinator has been in-serviced related to assuring that care plans accurately reflect the resident's current condition and the goals being measurable. The IDT team will meet each business morning and review the 24 hour report for any incidents, changes of condition, and the physicians' orders for each resident. At this time, the information will be reviewed and the MDS/Care Plan Coordinator will update the plan of care related to any needed changes and include measurable goals. In addition, the IDT will work with any outside services such as Hospice to assure that the plan of care is appropriate and inclusive of the necessary services with measurable goals. Were any in-services/education provided to address deficient practice? The MDS/Care Plan Coordinator has been in-serviced related to assuring that the plan of care accurately reflects the resident's condition and that the goals are measurable. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents related to appropriate	

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	Assistant on 9/16/13 at 2:45 p.m., indicated there hasn't been an Activities Director for several months. The Activity Assistant indicated he was "filling in" and was waiting on training from the company. He indicated his background was social service and he "helps out where ever needed." An interview with the MDS Coordinator on 9/17/13 at 9:50 a.m., indicated she updates care plans as she received orders. The MDS Coordinator indicated she had to "dig" in resident charts to be able to determine if interventions were effective. The MDS Coordinator indicated there was no communication with staff regarding the interventions. 2. Resident #52's record was reviewed on 9/16/13 at 9:48 a.m. Resident #52's diagnoses included, but were not limited to, senile dementia, CVA (stroke), paralysis and dysphasia (difficulty swallowing). Review of September 2013 Physician Recapitulation order, indicated an order dated 8/26/13, indicated the resident could have soft foods such as ice cream, shakes, pudding for pleasure foods. Resident could have		care planning and measurability of goals. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The MDS/Care Plan Coordinator, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy was appropriate and utilized for the in-service training F279 Were other residents identified with potential to be affected by the deficiency? All care plans were reviewed. There were no other residents identified to be affected by this deficiency. What measures and systemic changes were put in place to assure deficient practice does not recur? The MDS/Care Plan Coordinator has been in-serviced related to assuring that care plans accurately reflect the resident's current condition and the goals being measurable. The IDT team will meet each business morning and review the 24 hour report for any incidents, changes of condition, and the physicians' orders for each resident. At this time, the information will be	

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	speech therapy feedings per ST (speech therapy) only. Family could give the soft foods. On 8/23/13, speech treatment was recommended three times a week for 30 days as indicated. A care plan initiated on 8/4/13, indicated the resident pockets food during meals and was at risk for choking. The interventions indicated to encourage the resident to swallow food or spit it out, consult with dietary and physician as needed and check mouth for food pocketing as needed after meals. There was lack of documentation to indicate the resident would have soft foods such as ice cream, shakes, pudding for pleasure foods, the resident would have speech therapy feedings per ST (speech therapy) only and family would give the soft foods. The care plan did not indicate speech treatment was recommended three times a week for 30 days as indicated. An interview with the MDS Coordinator on 9/17/13 at 9:50 a.m., indicated she updates care plans as she received orders. The MDS Coordinator indicated she had to "dig" in resident charts to be able to determine if interventions were		reviewed and the MDS/Care Plan Coordinator will update the plan of care related to any needed changes and include measurable goals. In addition, the IDT will work with any outside services such as Hospice to assure that the plan of care is appropriate and inclusive of the necessary services with measurable goals. Were any in-services/education provided to address deficient practice? The MDS/Care Plan Coordinator has been in-serviced related to assuring that the plan of care accurately reflects the resident's condition and that the goals are measurable. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents related to appropriate care planning and measurability of goals. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The MDS/Care Plan Coordinator, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy was	

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	effective. The MDS Coordinator indicated there was no communication with staff regarding the interventions. 3. Resident #34's record was reviewed on 9/16/13 at 10:15 a.m. Resident #34's diagnoses included, but were not limited to, depression, dementia, tachycardia and arthritis. June 2013 Recapitulation orders indicated the resident had an order for 2 Cal (dietary supplement to help gain and maintain weight) 90 ml (milliliters) twice a day with Med Pass with a starting date of 8/24/12. The June orders also indicated the resident was on a regular diet with no concentrated sweets with a starting date of 3/19/11. A physician order dated 6/17/13, indicated Pro Stat (protein drink with 101 calories) 101, 30 ml twice a day. A physician order dated 6/29/13, indicated Pro Stat 101, 90 ml twice a day. July 2013 Recapitulation orders indicated the resident had an order for 2 Cal 90 ml (milliliters) twice a day with med pass with a starting date of 8/24/12, Prostat 101, 30 ml twice a		appropriate and utilized for the in-service training F 280 –RIGHT TO PARTICIPATE PLANNING CARE REVISE CP IT IS THE POLICY OF THE ALPHA HOME TO INCLUDE THE RESIDENT UNLESS ADJUDGED INCOMPETENT OR FOUND OTHERWIS TO BE INCAPACITATED TO PARTICIPATE IN THE PLANNING CARE AND TREATMENT OR CHANGES IN CARE AND TRREATMENT. Corrective Action Taken Related to this Finding: Resident #6 is no longer a resident at the Alpha Home. Resident #52 care plan was revised to include the ability of speech therapy and family members to give her soft foods, pleasure foods for 30 days as indicated. Communication was given to staff and guardian. Resident #34 the care plan has been revised to reflect discontinuance of all extra caloric items and the initiation of a weight loss plan. Communication has been given to the staff and responsible family member regarding this change Resident #1 care plan was revised to include non -pharmacological interventions for decreased behaviors, anxiety, dementia with behavior disturbances, and pain. Included in this revision is to provide diversionary activities including 1:1 conversation, repositioning, and verbal redirection. Communication has	

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	day with a starting date of 6/17/13. The resident continued to be on a regular diet with no concentrated sweets with a starting date of 3/19/11. A Dietary Quarterly Note dated 7/16/13, indicated the resident received extra calories with Med Pass. The note indicated a request for 2 Cal to be discontinued. A Care Plan Meeting sheet dated 7/26/13, indicated the resident was on a therapeutic diet. A physician order dated 9/9/13, indicated to discontinue "previous" diet and wrote a new order for a regular diet. Review of the care plan updated on 9/9/13, indicated the resident has fluctuating weight and was obese. Interventions indicated 90 ml 2 Cal twice a day with med pass, 90 ml of Protstat twice a day with Med Pass, snacks between meals, per request and Ensure or Ensure pudding at supper. The care plan had been updated four other times. There was no date to indicate when the interventions was initiated and no indication when snacks was changed or discontinued.		been given to the family and staff regarding this change. Resident #26 Care plan was revised to reflect the need for large print due to impaired vision related to the diagnosis of glaucoma. And includes the need for large print as an intervention. Communication has been given to the staff and POA. II. Other Residents with Potential to be affected by this finding will be identified by: All other residents having the potential to be affected by the finding will have their care plans reviewed with the internal audit. weekly monitoring will continue with MDS coordinator and the director of nurses. The unit charge nurse will comply by communicating any new orders, significant changes, or other pertinent information to the twenty hour report, for communication and inclusion in the care plan. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All the residents care plan audits will address new physician orders, significant, changes , updated progress noted from services provided and contributing information that addresses the resident care. The charge nurse will continue to monitor the twenty four reports with the audit sheets for communication and compliance with review by the Director of nurse. All care plans are reviewed for additional input from the audit	

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	An interview with the Registered Dietician on 9/10/13 at 10:00 a.m., indicated the resident could lose weight and the doctor agreed. The care plan had not been updated to indicate the resident was on a weight loss plan. An interview with the MDS Coordinator on 9/17/13 at 9:50 a.m., indicated she updated care plans as she received orders. The MDS Coordinator indicated she had to "dig" in resident charts to be able to determine if interventions were effective. The MDS Coordinator indicated there was no communication with staff regarding the interventions. 4. Resident #1's record was reviewed on 9/17/13 at 9:30 a.m. Resident #1's diagnoses included, but were not limited to anxiety, dementia and COPD (lung disease). The September 2013 Physician Recapitulation orders indicated the resident was receiving Lidoderm 5% patch topically to mid back daily for pain with a starting date of 1/10/13, Exelon 9.5 mg (milligrams)/24 hr (hour) patch topically daily for dementia with a starting date of 1/10/13, Trazadone 25 mg daily at		sheets, behavior sheets, and direct care assignment sheets and communicated to the staff. IV. Corrective Actions will be monitored to Ensure Compliance by: *10-16-13	

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	bedtime for sleep with a starting date of 1/10/01, Depakote 125 mg twice a day for behaviors with a starting date of 7/11/13, and Lorazepam 0.5 mg every 8 hours as needed for anxiety with a starting date of 7/2/13. A care plan dated 7/11/13 for reduction in Depakote/increased risk for behaviors, did not indicate non-pharmacological interventions for reducing behaviors. A care plan dated 1/11/13 for anxiety, did not indicate non-pharmacological interventions for reducing behaviors. A care plan dated 1/11/13 for pain to the mid back, did not indicated non-pharmacological interventions for reducing pain. A care plan dated 1/11/13 for dementia with behavior disturbances, did not indicate non-pharmacological interventions for reducing behaviors. An interview with the MDS Coordinator on 9/17/13 at 9:50 a.m., indicated she updated care plans as she received orders. The MDS Coordinator indicated she had to "dig" in the resident's chart to be to determine if interventions were effective. The MDS Coordinator			

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	indicated there was no communication with staff regarding the interventions. 5. Resident #26's record was reviewed on 9/16/13 at 11:20 a.m. Resident #26's diagnosis included, but were not limited to, glaucoma A social service quarterly review dated 2/22/13, indicated the resident had impaired vision and was able to see large print, but not regular print. A care plan dated 11/29/12, indicated a change in eye drops. Goal date was 8/25/13. Interventions did not indicate the resident's impaired vision and need for large print. A care plan dated 4/10/12, did not indicate the resident's impaired vision and need for large print. A care plan dated 9/23/11, indicated the resident had intraocular pressure, glaucoma and dry eyes. Goal was updated 9/14/13 and did not indicate the resident's impaired vision and need for large print. An interview with the MDS Coordinator on 9/17/13 at 9:50 a.m., indicated she updated care plans as she received orders. The MDS			

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	Coordinator indicated she had to "dig" in resident charts to be able to determine if interventions were effective. The MDS Coordinator indicated there was no communication with staff regarding the interventions. 3.1-35(d)(2)(B)			

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F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on observation, record review, and interview, the facility failed to assess residents with positioning/balance issues so that appropriate services and/or assistive devices would be provided to ensure residents maintained the highest practicable physical well-being. This deficient practice affected 1 of 4 residents reviewed for positioning (Resident #33). Findings include: Resident #33's record was reviewed on 9/13/2013 at 2:11 P.M. Resident #33 had diagnoses which included, but were not limited to, diabetes and dementia. A quarterly MDS (minimum data assessment tool) dated 6/25/2013, indicated Resident #33 had cognitive impairment with a BIMS (brief interview mental status assessment tool) score of 3 out of 15 and was totally dependent on staff for transfers and bed mobility.	F000309	F309 Were other residents identified with potential to be affected by the deficiency? All residents have been reviewed related to positioning and assistive devices and no other residents were identified to be affected by this deficiency. What measures and systemic changes were put in place to assure deficient practice does not recur? All nursing staff has been in-serviced related to proper positioning and assistive devices related to the residents. The in-service included identifying residents that are not positioned properly during daily care and observation. Nursing staff has also been trained to assure that if any resident is identified as have positioning issues that they are to be addressed immediately with interventions implemented as appropriate. The Director of Nursing, or designee, will be making rounds several times throughout the day to assure that residents are positioned appropriately. Were any in-services/education provided to address deficient practice? All	10/16/2013

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	The following were observations of Resident #33 leaning to the side without support to maintain an upright position: On 9/11/2013, during constant observations from 9:50 A.M. to 10:08 A.M. - Resident #33 was observed in a wheelchair in the activity room. Resident #33 repeatedly fell to right side of his wheel chair. His arm slipped off of the arm of wheel chair which caused him to lean to the right five times during this observation. Resident #33 was observed two additional times to lean so far to the right his right arm dangled over the wheel chair and his hand touched the floor. Resident #33 was repositioned himself however; he could not keep from leaning and falling to his right side. On 9/18/2013 at 10:25 P.M., Resident #33 observed sitting in a wheel chair in the TV lounge. Resident #33's right arm continued to frequently slip off the arm of the chair causing him to fall to the right. Resident #33's record lacked documentation his inability to remain in an upright position had been assessed.		nursing staff was in-serviced related to positioning/assistive devices for residents Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents related to assuring proper use of assistive devices and positioning of residents. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy was utilized for re-training. F309 Were other residents identified with potential to be affected by the deficiency? All residents have been reviewed related to positioning and assistive devices and no other residents were identified to be affected by this deficiency. What measures and systemic changes were put in place to assure deficient practice does not recur? All nursing staff has been in-serviced related to proper positioning and assistive devices related to the residents.	

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	During an interview on 9/16/2013 at 2:30 P.M., with the Director of Nursing (DON), the Social Service Director (SSD), and the Administrator present, the DON indicated Resident #33 had been evaluated in the past but not recently because he was able to straighten up on his own. At this time documentation was requested which indicated Resident #33 had been assessed and any recommendations that were made as a result of the assessments. During an interview on 9/17/2013 at 1:30 P.M., the DON indicated she was unable to provide documentation which indicated Resident #33 had been assessed regarding positioning. During an interview on 9/18/2013 at 12:31 P.M., the DON indicated she had Resident #33 evaluated yesterday. The DON stated, "No, he had not been seen prior to yesterday regarding positioning. We had them look at him yesterday. Don't know the results." The DON indicated she believed Resident #33 needed a different type of wheelchair. 3.1-37(a)		The in-service included identifying residents that are not positioned properly during daily care and observation. Nursing staff has also been trained to assure that if any resident is identified as have positioning issues that they are to be addressed immediately with interventions implemented as appropriate. The Director of Nursing, or designee, will be making rounds several times throughout the day to assure that residents are positioned appropriately. Were any in-services/education provided to address deficient practice? All nursing staff was in-serviced related to positioning/assistive devices for residents Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to audit 5 residents related to assuring proper use of assistive devices and positioning of residents. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to	

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			address the deficient practice? The current facility policy was utilized for re-training. F 309– PROVIDE CARE SERVICES FOR HIGHEST WELL BEING It is the policy of the Alpha Home to assure each resident has the appropriate services and appropriate assistive devices to maintain the highest level of physical well being. Corrective Action Taken Related to this Finding: Resident # 33 has a new physician order for an OT evaluation for seating and repositioning. Recommendations will be followed upon completion. The MDS coordinator collects all the information for documentation into the residents individualizes care plans. II. Other Residents with Potential to be affected by this finding will be identified by: All other residents having the potential to be affected by the finding are identified and referrals made to the therapy department after notification to the attending physician and the orders are received from the physician. These orders are then communicated by the charge nurse to the therapy department. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All the residents care plan audits have been completed. Care Plans will additionally address new physician orders, significant changes , updated progress	

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			noted from service provides and contributing information daily to the therapy department that address the resident care. The charge nurse will monitor the twenty four reports with the audit sheets for communication and compliance with review with the Director of nurse. All care plans are reviewed for additional input from the audit sheets, behavior sheets, and direct care assignment sheets. The audit sheets, and resident updates are communicated to the staff. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by. The interdisciplinary each week to conduct correct action review of the audits. These daily audit sheets completed by the nurses, and reviewed by the interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. V.	

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F000311 SS=H	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. Based on observation, interview, and record review, the facility failed to ensure residents received restorative services needed to prevent loss of ability to ambulate and decline in strength, transferring skills, locomotion skills, and range of motion for 5 of 5 residents reviewed for restorative services. (Residents #41, #32, #28, #34, and #49). Findings include: 1. Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Resident #41 had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, anemia, a history of a stoke with left sided weakness, a recent urinary tract infection (UTI), and seizures. A five day significant change Minimum Data Set Assessment Tool (MDS) dated 4/19/13, indicated Resident #41 was re-admitted to the facility on 4/12/2013, after being discharged from an acute care hospital, where he received treatment for an UTI. This	F000311	F312 Were other residents identified with potential to be affected by the deficiency? All residents are receiving ADL care including showers, bathing, hair washing, and nail care at this time. What measures and systemic changes were put in place to assure deficient practice does not recur? All nursing staff have been in-serviced related to assuring that resident receive all ADL care and personal hygiene services as part of their plan of care. Nurses will be responsible for assuring that those residents scheduled that require care receive the services on their designated shifts. Nursing Administration will be making rounds daily to assure that all residents are receiving their personal care in accordance with the services needed. Were any in-services/education provided to address deficient practice? All nursing staff has been in-serviced on providing appropriate ADL services Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly audit 5 residents related to provision of services including showers/baths,	10/16/2013

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	MDS indicated Resident #41 was cognitively intact with a BIMS (brief interview mental score cognition assessment tool) score of 14:15, totally dependent on the assistance of one staff for locomotion, dressing, personal hygiene, bathing, transfers, toileting, and had received physical therapy and occupational therapy. During an observation on 9/10/2013 at 2:29 P.M., Resident #41 was observed sitting in his wheel chair in his room. Resident #41 had a therapeutic glove on his left hand/arm and leaned to the left in the wheel chair. During an interview on 9/10/2013 at 2:29 P.M., Resident #41 stated, "I was walking. Therapy is gone. They had someone in here. Had me lift my leg 20 times. I was walking in July now I can't.... They packed up on a Friday. They moved all the therapy stuff out. Nobody knows what happened to it-where it went. I came here for therapy. I was making good progress. They still charge me for rehabilitation and I ain't getting nothing. If I am going to be an invalid bed patient I am going to get the (curse word). I am not that far out. With help I can walk again but I need it every day. They won't tell me		hair care, and nail care in accordance with the plan of care. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The facility's current policy was utilized for in-services. F312 Were other residents identified with potential to be affected by the deficiency? All residents are receiving ADL care including showers, bathing, hair washing, and nail care at this time. What measures and systemic changes were put in place to assure deficient practice does not recur? All nursing staff have been in-serviced related to assuring that resident receive all ADL care and personal hygiene services as part of their plan of care. Nurses will be responsible for assuring that those residents scheduled that require care receive the services on their designated shifts. Nursing Administration will be making rounds daily to assure that all residents are receiving their personal care in accordance	

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	anything. I will go someplace else. I don't have a choice. Either leave and get therapy or turn into a vegetable and they are taking my money. They get money from Medicare and Medicaid and my money. They are not giving me the service. You ask them about therapy and they say tomorrow or next week. Next week or tomorrow never comes." An un-timed physician's order dated 6/10/2013, indicated, "Late entry for 6/3/2013, extend skilled PT (physical therapy) 5/wk (week) X 6 wk for therapy exs (exercises) ble (bilateral extremities), therapy activity... gait transfer training modalities as indicated to improve functional mobility." A physical therapy weekly summary note dated 6/24/2013-6/28/2013, indicated Resident #41 was able to ambulate, with minimum to moderate assist, thirty feet with two repetitions per session, required minimum assistance to sit up from a flat position and to stand from a sitting position, and was independent with wheel chair mobility. This PT note indicated, "Pt (patient) is improving toward all goals of gait/transfers/balance and strength. Rehab (rehabilitation) potential is		with the services needed. Were any in-services/education provided to address deficient practice? All nursing staff has been in-serviced on providing appropriate ADL services Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly audit 5 residents related to provision of services including showers/baths, hair care, and nail care in accordance with the plan of care. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The facility's current policy was utilized for in-services. F 312 –ADL CARE PROVIDED DEPENDENT RESIDENTS IT IS THE POLICY OF THIS FACILITY TO CARRY OUT THE ACTIVITIES OF DAILY LIVING NECESSARY TO MAINTAIN GOOD NUTRITION, GROOMING, PERSONAL AND ORAL HYGIENE. Corrective Action Taken Related to this	

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	good. Cont (continue) tx (treatment) as tolerated to achieve long term goals...." A telephone order dated 7/2/2013-4:00 P.M., indicated, "Late entry for 6/28/2013 d/c (discontinued) from skilled ot/pt (occupational therapy/physical therapy) at maximal functional level " This order indicated the facility was to provide restorative services six days a week for six weeks beginning 7/8/2013. These restorative services were to include therapeutic exercises to all extremities, left hand splint, and ambulation with platform rolling walker. A restorative nursing program therapy referral form dated 7/8/2013, indicated Resident #41 needed the following restorative programs: ROM (range of motion) exercise, splinting, and ambulation. Problems: 1) Decreased active mobility LUE (left upper extremely). 2) Decreased strength LLE (left lower extremely). 3) Decreased ambulation skills. 4) Decreased transfer skills. Precautions: Fall Risk. Resident's functional status upon d/c (discontinue) from therapy: Ambulation with PRW (platform rolling walker) x 50 feet with min (minimum)		Finding: Resident # 41 has remained in the evening shower list and scheduled on the days a male shower aide can be scheduled to assure that it is offered each time he is scheduled to receive one. Because of residents rights issues care givers are aware that they must report any refusal of receiving a shower. Resident #34 has been offered a shower and shampoo by the day shower aide. The results have been reported to the day shift charge nurse. The care giver assigned to resident #33 was counseled on failure to clean under the nails. This was a in the form of a verbal warning. II. Other Residents with Potential to be affected by this finding will be identified by: All other identified residents having the potential to be affected by the finding will be monitored to assure that this deficient practice does not reoccur. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All the residents care plan audits have been completed. Care Plans will additionally address new those who are tetermined to require complete assistance with their ADL's. All care plans are reviewed for additional input from the audit sheets, behavior sheets, and direct care assignment sheets. The audit sheets, and resident updates are communicated to the staff.	

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	A (assist) of 1, transfers with min A of 1 using small steps, strength fair... LU/LE (left upper/lower extremities), splint with edema-glove to L(left) hand/wrist. Program goals: 1) Ambulate with PRW X 75 feet with min A of 1. 2) Decrease edema in L hand. 3) Transfer with CGA (contact guard assist) min A of 1 using small steps. 4) Increase strength LLE (left lower extremities) to fair. Instructions included: 1) PROM (passive range of motion) to left upper extremities with support to his shoulder, massage hand and position in splint. (Monitor splint during the day), 2) Ambulation in //(parallel bars) PRW with min (minimum) assist of 1) PRW additional sup (support) to follow with wc (wheel chair). 3) AAROM/AROM (active range of motion) exs (exercise) to BLE (bilateral lower extremities) in sitting at 25/reps (repetition)/ each, bike X 15 minutes.... Special equipment: PRW. Start Date 7/8/ 2013. Frequency and Duration 6/wk X 6 wks (8/30/2013).... Copies given to (1) Therapist, (2) Restorative aide, (3) original in chart." Range of motion program records dated July, August, and September 2013, indicated, "Daily Program Documentation for		IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by the interdisciplinary each week to conduct correct action review of the audits. These daily audit sheets completed by the nurses, and reviewed by the interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. V. Corrected Action Completion Date *10-16-13	

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	Restorative/Rehabilitation Nursing.... Goals: 1. Ambulate with personal roller walker at 75 feet with minimal assist of one. 2. Decrease edema in left hand. 3. Transfer with contact guard assist min (minimum asst of one using small steps. 4. Increase strength left lower extremities to fair. Programs: ambulation, ROM, splint/brace training...." These records indicated: Week 1: July 8-14, 2013, Resident #41 received restorative ambulation services one day out of seven (July 12). The record lacked documentation ROM restorative services were provided this week. The record indicated Resident 41's progress for that week was, "Not any." Week 2: July 15-21, 2013, Resident #41 received restorative ambulation and ROM services two out of seven days (July 17 and 18). The record indicated Resident 41's progress for that week was, "Not enough." Week 3: July 22-28, 2013, Resident #41 received ambulation and ROM restorative services five out of seven days (July 22, 23, 26, 27, and July 28). The record indicated Resident 41's progress for that week was, "Not			

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	enough." The record lacked documentation splint/brace training services were provided during the month of July 2013. Week 4: July 29-August 4, 2013, the record lacked documentation which indicated Resident #41 received ambulation, ROM, or splint/brace training restorative services. The record indicated Resident 41's progress for that week was, "Not enough." Week 5: August 5-11, 2013, Resident #41 received restorative ambulation, ROM, and splint/brace training services two out of seven days (August 6 and 7). The record indicated Resident 41's progress for that week was, "Not enough restorative this week." Week 6: August 12-18, 2013, Resident #41 received ambulation restorative services and ROM services six times during the week (August 12, 12, 14, 15, 16 and August 17), and brace/splint training services four out of seven days (August 12, 13, 14, and August 15). The record indicated Resident 41's progress for that week was, "Patient did good with			

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	Range of motion." The record lacked documentation of his ambulation progress. Week 7: August 19-25, 2013, Resident #41 received ambulation and ROM restorative services six days August 19, 20, 21, 22, 23, 24, 2013). The record lacked documentation resident #41 received splint/brace training services this week. The record indicated Resident 41's progress for that week was, "Patient able to move the right side of limbs." The record lacked documentation of his ambulation progress. Week 8: August 26-September 1, 2013., Resident #41 received ambulation and ROM restorative services five out of seven days (August 26, 27, 29, 30, and August 31). The record lacked documentation brace/splint training services were provided during this week. The record indicated Resident 41's progress for that week was, "Patient doing good with ROM and can still move the right side." The record lacked documentation of his ambulation progress. This record indicated from September 2-7, 2013, Resident #41 received			

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	ambulation restorative services five out of seven days on September 3, 4, 5, 6, and September 7. The record lacked documentation which indicated Resident #41 received ROM or brace/splint services during this week. The record indicated Resident 41's progress for that week was, "Patient can move right side of limbs, but need help with left." The record lacked documentation regarding his ambulation status. A current care plan updated on 8/20/2013, indicated Resident #41 was at risk for falls due to a diagnosis of a stroke and left sided hemi-paresis. The goal listed was Resident #41 would not have falls or injuries from falls. Interventions listed to meet this goal included staff were to encourage him to attend and participate in therapy. During an interview on 9/12/2013 at 1:15 P.M., when asked what happened to the facility's therapy services, the Director of Nursing (DON) replied, "I don't know what happened. About two weeks ago they just pulled out of here." When asked how the facility was providing therapy services to the residents, she replied, "We have someone come in."			

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	During an interview on 9/12/2013 at 3:25 P.M., Resident #41 stated, "Therapy doctor came today. Said it may be tomorrow or Monday. He said if he got the word today he would start tomorrow. He is waiting on my doctor. First week in July they left not two weeks ago. They had me walking with a special walker to brace this arm. I could walk across the room up to three times. Now I have become a vegetable. I am getting weaker waiting on tomorrow." During an interview on 9/12/2013 at 4:00 P.M., the DON was asked to provide all documentation regarding Resident 41's therapy including, but not limited to, care plans, physician's orders, therapy notes, restorative notes, interdisciplinary notes, documentation of restorative services provided, documentation of services not provided and why, contact numbers for current and previous therapy providers, and names of staff responsible for providing restorative services to residents. During an interview on 9/13/2013 at 8:08 A.M., the facility's previous rehabilitation provider's (PRP) Staff #1 indicated their company left officially on June 30, 2013. Therapy discontinue orders had to be written			

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	because their company was leaving not because residents did not need therapy. Staff #1 stated, "I am unable to elaborate on why we are no longer there. That would be a question for the CEO.... There had to be an order to discontinue therapy for (Resident #41 named) because we left the building. I am sure the new therapy company would have picked him up. He was doing well and walking. He would have benefited from continued therapy. I don't think they have a restorative nursing program in the building." At this time, the case load of residents who were receiving therapy and would have remained on therapy if the they would not have left the building, was requested. PRP Staff #1 indicated a therapist would provide that information. During an interview on 9/13/2013 at 9:40 A.M., PRP Physical Therapist #2 indicated Resident #41 was progressing well in therapy. PRP Physical Therapist #2 stated, "He was doing well. Walking at least 30 feet. I don't have my records in front of me. If we would of stayed he would have remained on therapy." PRP Therapist #2 indicated Resident #41 had received their services prior to being sent to the hospital due to a severe			

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	urinary tract infection and pneumonia. PRP Therapist #2 stated, "When he returned from the hospital we saw a different decline. Overall weakness. His last hospital stay wiped him out. What we had hoped was we were going to be able to resolve the issues with the Administrator and we could resume therapy with the residents. That's why we didn't do permanent exit type documentation. We were not planning on exiting. Initially we thought we would resolve and come back in the door. We wrote temporary orders on physician's phone orders that the patients were to be discharged from skilled therapy but we recommended nursing write therapy restorative plans. We wanted them to write the plan. They know their staffing needs. If we wrote all these lofty goals and they couldn't do it. We wanted to base it on ROM, walking, transferring to and from toilet to keep them agile until therapy could resume.... We thought they hired someone else and we were put to the back burner. Absolutely, he would have continued to receive therapy until he would been able to be a min (minimum) assist to toilet x 1. Would have continued therapy until he was overall 50 percent mod (moderate) assist with all ADLs (activities of daily living). His brother was so exited he			

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	was walking. We didn't want him to be worse. We knew we could get him better." During an interview on 9/13/2013 at 11:19 A.M., Restorative Certified Nursing Assistant (RCNA) #1 indicated she had been providing Resident #41 with "Basically ROM." RCNA #1 stated, "He can't move his right side. We had the bars in the room. We would stand him up but they are gone." RCNA indicated she didn't know how long the bars had been gone. She indicated she did not work with Resident #41 until therapy left. RCNA #1 stated, "She told me if I could have help- stand him up. Basically, what I did was ROM until I felt he was strong enough to stand up. When I had the bike I would put him on the bike. It's all passive. I've never seen him walk. I never walked him out of the parallel bars because of safety. That's where I felt comfortable with his chair behind him. We only did it four or five times over two week time.... They gave me the paper July 8. It was on my desk. By the time I wrote it up. I was on the floor. Short of help by the time I got it started. Don't know exactly .... " RCNA #1 indicated she was the only RCNA and couldn't provide the restorative services recommended by			

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	therapy. RCNA indicated she was pulled to the floor to work as a CNA (certified nursing assistant) because the facility did not have enough staff. During an interview on 9/13/2013 at 1:02 P.M., the facility's current therapy provider's staff, PTA (physical therapy assistant) #3 stated, "One day down and three days to recover for someone my age. For these people, one day down and it is a loss. The word of mouth here is there has been a big decline. I talked to (Resident #41 named) but as not as an evaluation. I haven't seen anything with him. I am here once a week.... They don't seem to have a system to let us know who needs what." During an interview on 9/17/2013 at 12:15 P.M., the facility's current therapy provider's staff, PT (physical therapist) #4 indicated he had not evaluated Resident #41 because he had not received an order to evaluate Resident #41. PT #4 stated, "We are here for only a couple of weeks. They need to communicate with us. I told him (Resident #41) we could not do anything until we have doctor's orders. The social worker went with me last Thursday 9/12/2013. He expressed his concerns about waiting			

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	to be on services...." When asked if he was aware Resident #41 had an order for a PT/OT evaluation dated 9/13/2013, he replied, "No, I didn't even know they got the doctor's order. May I please see it?" PT #4 indicated the facility was aware he was the contact person and they did not notify him the order for the evaluation had been obtained. PT #4 stated, "We are only here until the end of the month. We gave them a letter telling them that. After that I don't know what is going to happen.... One week is way too long to go without therapy-severe decline." During an interview on 9/18/2013 at 1:06 P.M., the DON indicated the order probably got missed. She indicated this happened with another resident and she would check to see if it was the same nurse. A nurse's note dated 8/12/2013-2:30 P.M., indicated, "Resident A (alert) and O (oriented) X 3 (person, place, and, time). 0 agitation noted this shift. Res (resident) ext (extensive) assist with ADLs (activities of daily living) and transfers.... Edema noted to bil (bilateral lower ext (extremities). " An untimed nurse's note dated			

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	9/2/2013, indicated, "Res (Resident) continues to have generalized weakness. Res unable to pivot to W/C (wheel chair)...." A physician's order dated 9/13/2013-9:15 A.M., indicated Resident #41 may have a physical therapy/occupational therapy evaluation During a telephone interview on 9/19/2013 at 4:15 P.M., PRP Physical Therapist #2 indicated Resident #41 was evaluated the day he was made aware of the order. His evaluation indicated Resident #41's current status was, "A max assist to ambulate 15 to 20 feet at the most with a platform walker and physical assistance. His transfer ability is moderate. His sit to stand ability is moderate. His static dynamic balance is poor with max assistance. He is a high risk for falls and if he attempted to stand, walk, or reach for something without max assistance and a platform walker, he would fall." PRP Physical Therapist indicated his evaluation indicated Resident #41's status had declined since the last status recorded by the previous therapy company. 2. Resident #32's clinical record was reviewed on 9/11/13 at 10:15 A.M.			

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	Resident #32's diagnoses included but were not limited to, pneumonia, congestive heart failure, osteoarthritis, hypothyroidism, weakness and hypertension. Resident #32 was admitted to the facility on 4/19/13. Review of the "Physical Therapy Evaluation/Certification" dated 4/19/13, indicated Resident #32 ambulated 25 feet with a rolling walker with minimal assistance. Resident #32's short term goal was to ambulate with rolling walker seventy-five feet with minimal assistance. Resident #32's long term goal was to ambulate 125 feet to 150 feet. Review of the "Interdisciplinary Progress Note" dated 5/7/13, indicated Resident #32 was ambulating 60 feet with a rolling walker. A therapy noted dated 6/4/13, indicated Resident #2 was getting up unassisted and ambulating 50 to 60 feet using a rolling walker. A therapy note dated 6/28/13, indicated to discontinue skilled OT/PT (occupational therapy and physical therapy) due to the resident had met			

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	maximal functional level. The note indicated a recommendation for restorative nursing. Review of the "Restorative Nursing Program Therapy Referral Form" dated 7/8/13, indicated Resident #32 transfered 75 feet with a rolling walker with a minimal assist of one. Review of the "Daily Documentation for Restorative/Rehabilitation Nursing" indicated restorative nursing was not provided on July 1, 2, 3, 4, 5, 24, 25, 26, 29, 30 and 31, 2013. Restorative nursing was not provided August 1, 3, 4, 5, 8, 9, 18 and 19, 2013. A physical therapy order dated 8/20/13, indicated Resident #32 was to be seen three times a week for four weeks. A Physical Therpay note dated 8/29/13, indicated Resident #32 was unable to transfer or ambulate. During a telephone interview on 9/13/13 at 9:30 A.M., PRP PTA#1 stated, "Resident #32 on therapy. She was doing quite well when we left. We were leery of her doing ADL's (Activities of Daily Living) on her own. She was starting to get			

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	pretty close to independent/supervision/stand by assist. She was very close to being discharged." During an interview on 9/13/13 at 11:19 A.M., RCNA#1 indicated she was supposed to start working with Resident #32 on July 8, 2013 but she was pulled to the floor a lot in July. She indicated Resident #32 would refuse at times because she was tired. RCNA #1 indicated Resident #32 "never walked" for her. RCNA #1 indicated "I don't know what she would do for therapy." During an interview on 9/16/13 at 1:40 P.M., Resident #32 was observed in her room in a wheelchair. Resident #32 indicated, "When I first came in here I was in therapy and they were teaching me how to walk with the wheelchair. Now they are teaching me how to walk again. My legs just got stiff when they stopped." During an interview on 9/16/13 at 2:00 P.M., CNA # indicated "I just help her get out of bed and transfer, I don't walk her. I don't know how far she walks I just get her up to the bathroom and bed. If she does get physical therapy it would be documented in her chart."			

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	3. Resident #28 was observed in his room asleep in his wheelchair on 9/9/13 at 11:45 a.m. At 12:30 p.m., the resident was observed in the dining room in his wheelchair asleep. Resident #28 was observed in his room asleep in his wheelchair on 9/10/13 at 10:50 a.m. At 12:00 p.m., the resident was observed to be propelled by staff into the dining room for lunch. Resident #28's record was reviewed on 9/13/13 at 9:45 a.m. Resident #28's diagnoses included, but were not limited to CVA (stroke), weakness and unsteady gait (walk). The resident's Admission MDS (Minimum Data Set) Assessment dated 7/1/13, indicated the resident was mildly cognitively impaired. A therapy consent form from [name of therapy company) dated 6/22/13, indicated the resident was recommended for occupational and physical therapy services under Medicare Part A and Medicaid. Nursing notes dated 6/24/13, 6/25/13, 6/26/13, 7/1/13 and 7/22/13, indicated the resident was able to propel self in his wheel chair.			

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	A Physical therapy assessment note dated "week of 6/25-28/2013", indicated the resident indicated "I want to be able to walk better." Current mobility status indicated minimal assistance with a rolling walker and ambulated up to 60 ft (feet) with supervision. The note indicated rehabilitation potential was good. The resident was a stand by assist of one with "rolling" in bed, and minimal assistance of one for lying to sit and sit to stand from bed and wheel chair transfers to bed and toilet. The Balance dynamic stand was fair. Plan was to continue treatment per plan of care as tolerated, three times a week for four weeks with therapeutic exercise to BLE (bilateral lower extremities), therapy approved activities, gait/transfer training, improve functional mobility. A physician clarification order dated 6/25/13, indicated PT (physical therapy) three times a week for four weeks to improve functional mobility and pain management via therapy, exercises, therapeutic activity, gait/transfer training, balance activities and modalities as indicated. A physician clarification order dated 6/27/13, indicated Occupational			

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	therapy three times a week for four weeks increase independence with ADL's (Activity of Daily Living) and increase independence with wheelchair mobility, using therapeutic exercise, therapeutic activities, modalities, and self care retraining. The Occupational Therapy assessment information was not provided by the facility upon request. Review of the Restorative Nursing Program Therapy Referral form dated 7/8/13, indicated a decrease in ambulation skills and decrease strength to bilateral lower extremities. The record indicated the resident was ambulating with his rolling walker up to 75 feet with minimal assistance of one person, transfers with minimal assistance of one person and strength was fair to all extremities. The referral form indicated Occupational and Physical therapy recommended range of motion exercises and ambulation with goals provided. Instructions indicated to exercise the bilateral upper and lower extremities at 20 repetitions for each setting, bike exercises for 10 minutes for bilateral upper and lower extremities, ambulate with rolling walker up to 100 feet with minimal assistance of one person, and sit to stand from wheel chair to improve			

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	transfers. The start date was 7/8/13 six days a week for 6 weeks. Review of the "Range of Motion Program" form for July 2013, indicated the plan for the resident was to "(1) exercise bilateral upper/lower extremeties at 20 repetitions each setting and bike pedal for 10 minutes for bilateral upper/lower extremeties. (2) ambulate with rolling walker at 100 feet, contact guard assist with minimal assistance of one. (3) Sit to stand from wheel chair to improve transfers." The resident had not received services on July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 2013. A weekly progress note had an "X" through the comment sections and indicated "not enough restorative". Another form titled "Daily Program Documentation for Restorative/Rehabilitation Nursing" dated July 2013 was reviewed. The form had lines through the dates of July 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 16, 19, 21, 24, 25, 29, 30 and 31, 2013, indicating the resident was not seen for mobility training and range of motion. Review of the August 2013			

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	"Ambulation Program" form indicated the resident had not received services on August 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 18, 25 and 28, 2013. A weekly progress note dated 8/12/13 to 8/17/13, indicated the "Patient is only walking 50 ft (feet). I'm working with his ROM (range of motion) so legs can get stronger. A weekly progress note dated 8/19/13 to 8/24/13, indicated the resident was walking 50 ft. A weekly progress note dated 8/26/13 to 8/31/13, indicated the resident was still walking 50 ft. There was a 25 ft decline from 7/8/13 to 8/31/13. Review of the August 2013 "Range of Motion Program" indicated the resident had not received services on August 1, 2, 3, 4, 5, 6, 7, 11, 18, 25 and 28, 2013. There was a line through the weekly progress note for the week of 8/1/13 to 8/4/13. The weekly progress note for 8/8/13 to 8/10/13, indicated "not enough restorative." A physician order dated 8/15/13, indicated OT/PT (occupational and physical therapy) evaluation and treat as needed. A Physical Therapy Plan of Care dated 8/15/13 indicated the resident			

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	was assessed to be moderately dependent for transfer from sit to stand, bed to wheelchair, toilet and floor. Standing dynamic balance was poor. Gait analysis indicated the resident was able to ambulate 70 feet with moderate assistance. The restorative referral form dated 7/8/13, indicated the resident was ambulating 75 ft. with minimal assistance and standing dynamic balance was fair. Review of the "Occupational Therapy Plan of Care" dated 8/23/13, indicated the resident was assessed and short/long term goals were initiated. The Neuromuscular upper extremity range of motion indicated the resident demonstrated increased difficulty with left upper extremity. The clinical observations indicated the "resident presented with decreased strength, endurance, decreased independence and safety with self care performance and safety and poor mobility. The resident was unable to propel self in the wheel chair to 20 feet without fatigue." A therapy assessment dated 6/25/13, indicated the resident was able to propel self "ad lib in facility" in regards to distance propelled and the strength was fair to all extremities. During an interview on 9/12/13 at			

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	1:15 p.m., the DoN indicated she did not know what happened to the previous therapy company. The DoN indicated the company "pulled out of here." The DoN indicated they had "someone" coming in for therapy services. During an interview on 9/13/13 at 11:20 a.m., RCNA #1 indicated she was the only RCNA and she could provide the restorative services recommended by therapy. RCNA #1 indicated she had to be pulled away from her duties as a restorative aide and be put on the floor many times due to short staffing of CNAs'. RCNA #1 indicated she was using the equipment from the previous therapy company until the company had it removed on 9/10/13. During an interview on 9/13/13 at 12:00 p.m., the DoN indicated the RCNA #1 had to be pulled off of her assignment as a restorative aide due to staff quitting without notice. The DoN indicated the facility had suffered a lot this year. The DoN indicated the Board of Directors had been making cuts with staffing and they had not been able to replace staff due to money factors. The DoN also indicated she has had a difficult time finding staff with experience and skills			

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	needed for the residents. During an interview on 9/13/13 at 12:20 p.m., the current therapy provider's staff, PT (physical therapist) #4 indicated his company had signed a contract with the facility on 8/12/13. The therapist indicated the reason for the delay of assessing the resident was due to verifying insurance information. During an interview on 9/13/13 at 1:00 p.m., the current therapy provider's staff, PTA (physical therapy assistant) #3 indicated one day down would take three days to recover for someone like herself. PTA #3 indicated it would take the residents' longer to recover due to their and co-morbidities. The PTA #3 indicated she had heard there was a big decline in the facility. The PTA #3 indicated she was at the facility once a week and PT #4 was at the facility twice a week. PTA #3 indicated the facility did not have a system to notify their company of resident needs. During an interview on 9/18/13 at 2:10 p.m., the DoN indicated RCNA #1 was the only restorative aide. The DoN indicated they had put a plan into place to provide services to residents who required therapy while			

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	the facility made arrangements for another company to start. The facility did not have enough staff to meet the residents needs. RCNA #1 was frequently removed from her responsibilities of a RCNA. 4. Resident #34's record was reviewed on 9/16/13 at 10:15 a.m. Resident #34's diagnoses included, but were not limited to, depression, dementia, hypertension, and tachycardia (fast heart rate). Review of the Annual MDS (Minimum Data Set) Assessment dated 7/19/13, indicated the resident was cognitively intact. A dietary quarterly note dated 7/16/13, indicated the resident weight was 198. The August TAR (Treatment Administration Record) indicated the resident's resident had an 18 pound weight loss and weighed 180 pounds on 8/28/13 A physician order dated 9/9/13, indicated the resident was to have speech therapy due to the resident spitting out food in a bag. During an interview on 9/17/13 at 11:00 a.m., the DoN indicated she			

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	was not able to locate a speech evaluation and did not know if speech therapy had been notified of the order. During an interview on 9/17/13 at 12:15 p.m., the facility's current therapy provider staff, PT (physical therapist) #4 indicated his company was only to be in the facility for a few weeks. PT #4 indicated the facility needed to communicate with his company in regards to new referrals/physician orders. PT #4 indicated he was not aware of the speech referral for the resident. During an interview on 9/18/13 at 9:45 a.m., Resident #34 indicated she had not been seen by anyone for speech. She had indicated she spits out meat after chewing it because she cannot break it down enough to swallow. During an interview on 9/18/13 at 12:30 p.m., the DoN indicated a nurse "dropped the ball" on referring the resident to therapy. When asked if therapy was notified on 9/17/13 during their visit, the DoN indicated "I am sure they did, but I will verify". An undated policy titled, "Restorative Nursing," was provided by the DoN on			

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	9/17/13 at 1:45 p.m. The policy indicated "The restorative nurse is trained and has an active program of restorative care which is an integral part of nursing services. This program is directed toward assisting each resident to achieve and maintain optimum level of self care and maximum level of functioning. The restorative nurse provides care daily for those who require their service. Each resident will be evaluated for his/her rehabilitative potential by the attending physician, with assistance by nursing staff and therapists as appropriate." A "Therapy Services Policy and Procedure" dated 2011, indicated "All referrals for therapy must present [sic] with a doctor's order. The orders will then be submitted to the therapy for their evaluation. The recommendations [sic] will then be given to the attending physician to verify and approve." 5. Resident #49's record was reviewed on 9/13/2013 at 9:30 A.M. Resident # 49 had diagnoses which included, but were not limited to, myoapathy (possible Gillian Barre), autism, and, malnutrition. A care plan note dated 3/20/2013,			

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	indicated Resident #49 was admitted to the facility for skilled nursing and therapy services with discharge plans to go home. An un-timed interdisciplinary (IDT) progress note dated 5/14/2013, indicated Resident #49 was, "being seen by PT/OT (physical therapy/occupational therapy) 3 X/wk with anticipated d/c (discharge)set for 6/11/2013. Pt (patient) is non-ambulatory at this time, bed mobility is min-mod A (minimum - moderate assist), standing transfers are mod-max A x 2 (moderate-maximum assist of two), pt (patient) is able to self propel w/c with max vc's (vocal cues) and multiple physical prompts. Pt is improving... up(upper) strength continues to be focus...." An un-timed IDT progress note dated 6/4/2013, indicated Resident #49 continued with OT/PT services with a tentative discharge date 6/30/2013. This note indicated Resident #49 had made progress with fine motor skills and had been able to self propel her wheel chair 20 feet with her leg and minimum assist. An un-timed IDT progress note dated 6/18/2013, indicated Resident #49			

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	continued with PT/OT services. Resident #49 had made progress and would continue with therapy services. A physician's order dated 7/2/2013-3:50 P.M., indicated, "Late entry for 6/28/2013, D/C from skilled OT/PT at maximal functional level. Recommendation to restorative nursing for therapeutic exs (exercises) all extremities, monitor wrist splints-6/wk X 6/wks (six times a week for six weeks) starting 7/8/2013." A restorative nursing program therapy referral form dated 7/8/2013, indicated Resident #49 needed the following restorative programs: "ROM (range of motion) exercise and splinting. Problems: 1) Decreased AROM (active range of motion). 2) Decreased strength all extremities). 3) Wrist drop B (bilateral) ue (upper extremities). 4) Decreased transfer skills. Precautions: Fall Risk. Contracture risk. Resident's status upon d/c (discontinue) from therapy: Transfer with minimum to moderate assist of one using stand pivot techniques, AAROM (active assist range of motion), WFG for all extremities, wearing B (bilateral) wrist splints at all times. Program goals: 1) Prevent contractures (B) wrists. 2)			

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	Maintain/improve transfers to min (minimum) A (assist) of one. 3) Increase strength of all extremities to fair. Instructions included: 1) AAROM (active assist range of motion) to all extremities in sitting at 20 reps/each. 2. AAROM exs (exercise) and gentle massage to wrists/hands with splints removed then put back on after exercises, clean hands/dry well. 3. Bike for B (bilateral) extremities. Start Date 7/8/2013. Frequency and Duration 6 times a week for 6 weeks (8/30/2013).... Copies given to (1) Therapist, (2) Restorative aide, (3) original in chart." A range of motion program record dated July 2013, indicated, "Daily Program Documentation for Restorative/Rehabilitation nursing.... Goals: 1. Prevent contracture both wrist. 2. Maintain/improve transfer to minimal assist of one. 3. Upper strength of all extremities to fair. Plan: Arrange for motion to all extremities in sitting at 20 reps/each, 2. arrange motion exercise and gentle massage to wrist/hands with splints removed, then put back on after exercises, clean hands/dry well 3. bike for bilateral upper/lower extremities at 10 minutes. Programs: ROM passive and splint/brace			

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	training...." This record indicated: Week 1: July 8-14, 2013, Resident #49 received passive ROM and splint/brace training restorative services three out of seven days (July 9, 10, 11). The record lacked documentation regarding Resident 49's progress for that week. Week 2: July 15-21, 2013, Resident #49 received passive ROM and splint/brace training restorative services six out of seven days (July 15, 16, 17, 18, 19, and 20). The record lacked documentation regarding Resident 49's progress for that week. Week 3: July 22-28, 2013, Resident #49 received passive ROM and splint/brace training restorative services five out seven days (July 22, 23, 26, 27, and 28). The record indicated Resident 49's progress for this week was, "Patient is willing to do exercises, she doing about 90% of exercise." Week 4: July 29-July 31, 2013, the record lacked documentation Resident #49 received restorative services this week. The record indicated Resident #49 moved to another facility on 8/1/2013. The			

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	record lacked documentation regarding Resident 49's progress for that week. The record lacked documentation Resident #49 received services with active assist range of motion or the use of the bike for bilateral upper/lower extremity exercise, as recommended in her restorative/rehabilitation recommendations, were provided during July. 2013. . During an interview on 9/13/2013 at 9:40 A.M., PRP Therapist #2 indicated Resident #49 was actively participating in therapy when the company left due to issues with the Administrator. PRP therapist #2 stated, "She would have continued. She was a young lady who came down with a progressive disease that was reversible with therapy. She was transferred to another facility because she and her family was tired of waiting for therapy." During an interview on 9/13/2013 at 11:19 A.M., Restorative Certified Nursing Assistant (RCNA) #1 indicated she had been providing Resident #49 with restorative services. RCNA #1 stated, "(Resident #41 named) was willing to			

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	do everything. She always asked me and I would take her in there.... I did what I could do. RCNA #1 indicated she was the only RCNA and couldn't provide the restorative services recommended by therapy. RCNA indicated she was pulled to the floor to work as a CNA (certified nursing assistant) because the facility did not have enough staff. During an interview on 9/13/2013 at 12:20 P.M., Resident #49's mom stated, "She was getting therapy. In the month of July they stopped. I started noticing she wasn't getting therapy. No, they didn't tell me. She required it. I began to ask and they said therapy was gone. They left. They were supposed to be getting it back. She was getting restorative therapy. That is just moving of her joints. She needed more. I had times when restorative therapy was giving it to her by an aide and when they were short staffed she wouldn't get it.... They kept saying they would get it back and someone would be coming in a couple of days but she needed it more frequently. She had splints on that did not belong to her and did not properly fit. They were too large. This happened back in May when she was on Medicaid. So, they put in the order for it. When she left she did not			

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	have proper splint size ...." Resident #41's mom indicated she moved her to another facility on August 1, 2013 because of the lack of therapy services. She indicated the new facility provided her with the proper splints, therapy, and her daughter had improved. During an interview on 9/18/2013 at 2:10 P.M., the DON indicated RCNA #1 was the only restorative aide. The DON indicated, although they had put a plan in place to provide services to residents who required therapy while the facility made arrangements for another company to start, the facility did not have enough staff to meet the residents needs. The DON RCNA #1 was frequently removed from her responsibilities of a RCNA to work the floor as a CNA. The DON indicated because RCNA #1 had to be pulled to the floor due to staffing issues, restorative recommendations to maintain or prevent a decline were not consistently provided to the residents. An undated policy titled, "Restorative Nursing," provided by the DON on 9/17/2013 at 1:46 P.M., indicated, "The restorative nurse is trained and has an active program of restorative care which is an integral part of			

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	nursing services. This program is directed toward assisting each resident to achieve and maintain optimum level of self care and maximum level of functioning. The restorative nurse provides care daily for those who require their service. Each resident will be evaluated for his/her rehabilitative potential by the attending physician, with assistance by nursing staff and therapists as appropriate." A "Therapy Services Policy and Procedure" dated 2011, indicated "All referrals for therapy must present [sic] with a doctor's order. The orders will then be submitted to the therapy for their evaluation. The recommendations [sic] will then be given to the attending physician to verify and approve." 3.1-38(a)(1)(B) 3.1-38(a)(2)(B)			

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 services were provided to residents who were dependent on staff for personal hygiene care. This deficient practice affected 3 of 15 residents reviewed for assistance with cleanliness and grooming (Resident #41, #33, and #34). Findings include: 1. Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Resident #41 had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, anemia, a history of a stoke with left sided weakness, a recent urinary tract infection (UTI), and seizures. A five day significant change Minimum Data Set Assessment Tool (MDS) dated 4/19/13, indicated Resident #41 was cognitively intact with a BIMS (brief interview mental score cognition assessment tool) score of 14:15, totally dependent on the assistance of	F000312	F312 Were other residents identified with potential to be affected by the deficiency? All residents are receiving ADL care including showers, bathing, hair washing, and nail care at this time. What measures and systemic changes were put in place to assure deficient practice does not recur? All nursing staff have been in-serviced related to assuring that resident receive all ADL care and personal hygiene services as part of their plan of care. Nurses will be responsible for assuring that those residents scheduled that require care receive the services on their designated shifts. Nursing Administration will be making rounds daily to assure that all residents are receiving their personal care in accordance with the services needed. Were any in-services/education provided to address deficient practice? All nursing staff has been in-serviced on providing appropriate ADL services Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly audit 5 residents related to provision of	10/16/2013

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	one staff for personal hygiene and bathing. During an interview on 9/10/2013 at 1:55 P.M., Resident #41 stated, "I am waiting on a shower now. It is supposed to be every Tuesday and Friday. It doesn't usually happen. They were doing it in the morning. They switched to night time trying to get people in to do it and it doesn't work all the time. I haven't had a shower in 3 weeks. They just wipe me up." During an interview on 9/16/2013 at 11:22 A.M., Certified Nursing Assistant (CNA) #1 indicated she had recently been assigned the position of "shower aide." She indicated she started this position two months ago. She indicated she worked days and provided most residents with their showers with the exception of the residents who received their showers in the evening. She indicated evening shift did not have a shower aide. CNA #1 stated, (Resident #41 named) is not on my schedule. He is in the evening. It has been two months since gave him shower. CNA #1 indicated if a resident refused a shower they were to document on a shower sheet that the resident refused and inform the nurse. CNA		services including showers/baths, hair care, and nail care in accordance with the plan of care. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The facility's current policy was utilized for in-services. F 312 –ADL CARE PROVIDED DEPENDENT RESIDENTS IT IS THE POLICY OF THIS FACILITY TO CARRY OUT THE ACTIVITIES OF DAILY LIVING NECESSARY TO MAINTAIN GOOD NUTRITION, GROOMING, PERSONAL AND ORAL HYGIENE. Corrective Action Taken Related to this Finding: Resident # 41 has remained in the evening shower list and scheduled on the days a male shower aide can be scheduled to assure that it is offered each time he is scheduled to receive one. Because of residents rights issues care givers are aware that they must report any refusal of receiving a shower. Resident #34 has been	

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	#1 was asked to provide documentation which indicated showers were provided to Resident #41. CNA #1 indicated Resident #41 was on an evening Tuesday/Friday shower schedule and when she took care of him he only refused a shower one time. CNA #1 indicated records lacked documentation which indicated Resident #41 had a shower in September 2013. CNA #1 provided a bathing record which indicated Resident #41 received a shower on August 16, 2013 and a record which indicated Resident #41 received a "bath" on August 30, 2013. CNA #1 indicated shower records lacked documentation which indicated Resident #41 received showers for the first two weeks of August 2013. During an interview on 9/16/2013 at 2:30 P.M., the Administrator, DON, and SSD were asked to provide all care plans pertaining to ADL care, documentation of showers, and documentation of showers offered but were refused for Resident #41. Review of a current care plan originally dated 10/8/2012, and last updated 8/20/2013, indicated Resident #41 required assistance with bathing due to a diagnosis of a stroke with left sided weakness.		offered a shower and shampoo by the day shower aide. The results have been reported to the day shift charge nurse. The care giver assigned to resident #33 was counseled on failure to clean under the nails. This was a in the form of a verbal warning. II. Other Residents with Potential to be affected by this finding will be identified by: All other identified residents having the potential to be affected by the finding will be monitored to assure that this deficient practice does not reoccur. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All the residents care plan audits have been completed. Care Plans will additionally address new those who are tetermined to require complete assistance with their ADL's. All care plans are reviewed for additional input from the audit sheets, behavior sheets, and direct care assignment sheets. The audit sheets, and resident updates are communicated to the staff. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by the interdisciplinary each week to conduct correct action review of the audits. These daily audit sheets completed by the nurses, and reviewed by the	

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	Approaches indicated Resident #41 would shower or bathe twice weekly and as needed. During an interview on 9/17/2013 at 1:45 P.M., the DON indicated documentation of showers and/or documentation of Resident #41 refusing showers was not available. She indicated she did not have an explanation as to why he was not getting showers as his care plan indicated he should. 2. Resident #33's record was reviewed on 9/13/2013 at 2:11 P.M. Resident #33 had diagnoses which included, but were not limited to, diabetes and dementia. A quarterly MDS (minimum data assessment tool) dated 6/25/2013, indicated Resident #33 had cognitive impairment with a BIMS (brief interview mental status assessment tool) score of 3:15, was totally dependent on staff for personal hygiene, and did not reject care. During observations of Resident #33 on 9/11/2013 at 10:07 A.M., on 9/17/2013 at 1:40 P.M., and 9/18/2013 at 9:20 A.M., a brown substance was noted under the finger nails of both his hands.		interdisciplinary team are submitted to the Quality Assurance Committee scheduled meeting monthly. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. V. Corrected Action Completion Date *10-16-13	

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	During an observation of Resident #33 on 9/18/2013 at 10:27 A.M., a brown substance was noted under the finger nails of both his hands. CNA #2 was present for this observation. CNA #2 indicated she was assigned to take care of Resident #33. CNA #2 stated, "Didn't know I was supposed to cut his nails. He is diabetic. I wash his hands but do not cut his nails." CNA #2 indicated she would clean under his nails. During an interview on 9/18/2013 at 10:29 A.M., Licensed Practical Nurse (LPN) stated, "The nurses cut his nails but the aides know they are supposed to clean them." 3. An interview with Resident #34 on 9/9/13 at 11:10 a.m., indicated she cannot remember the last time she had a bath and her hair washed. The resident's hair was observed to be unkept with a slight oily appearance. Resident #34's record was reviewed on 9/16/13 at 10:30 a.m. Resident #34's diagnoses included, but were not limited to, depression, dementia, hypertension, and tachycardia (fast heart rate). Review of the Annual MDS (Minimum Data Set) Assessment dated 7/19/13,			

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	indicated the resident was cognitively intact. An ADL (Activity of Daily Living) care plan updated on 7/24/13, indicated a goal date of 7/18/13. The care plan indicated the resident required assistance with ADL's bathing, dressing, grooming and personal hygiene tasks due to weakness from hospital stay and pneumonia. The shower schedule was observed hanging on the wall at the nurses' station. The shower schedule indicated the resident was to receive showers on Wednesday and Saturday's on evening shift. Shower sheets dated 8/28/13 indicated a bath was given. The shower sheet did not indicate if the resident's hair was washed. There were no other August shower sheets provided to indicate whether showers were provided o dates other than 8/28/13. Shower sheets dated 9/7/13 indicated the resident refused a bath due to the cold temperatures. A shower sheet dated 9/11/13 indicated a bath was given. The shower sheet did not indicate if the resident's hair was washed. There were no other September shower sheets provided to indicate showers given on other dates in September 2013.			

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	During an interview on 9/16/13 at 11:45 a.m., CNA/bath aide indicated there was not a permanent shower aide in the evening. The CNA/bath aide indicated evening shift were required to do one to two baths/showers a night. The CNA/bath aide indicated the she had not been informed if the resident had been refusing her showers/baths. The CNA/bath aide indicated she had not given the resident showers nor had she offered showers to the resident. An interview with LPN #11 on 9/18/13 at 9:40 a.m., indicated she did get informed when the resident refuse her showers/baths. LPN #1 indicated she was not aware if social service was notified of the resident's refusal of care. LPN #1 also indicated she did not know why the resident refuse showers/baths. 3.1-38(a)(3)(A) 3.1-38(b)(2)			

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F000315 SS=D	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, record review and interview, the facility failed to ensure a resident did not have a decline in urinary continence for 1 of 3 residents reviewed for incontinence. (Resident #A) Findings include: Resident #A's record was reviewed on 9/11/13 at 2:10 p.m. Resident #A's diagnoses included, but were not limited to, CVA (stroke) and dementia. A Comprehensive Admission MDS (Minimum Data Set) Assessment dated 2/12/13, indicated the resident was frequently incontinent of urine (greater than 7 incontinent episodes, but at least one continent episode, in a week). The MDS indicated the resident was not on a toileting	F000315	F315 Were other residents identified with potential to be affected by the deficiency? All residents have been reviewed for incontinence. All residents identified as having incontinence have been assessed and where appropriate toileting programs have been established What measures and systemic changes were put in place to assure deficient practice does not recur? All nursing staff has been in-serviced related to provision of services in accordance with the plan of care specifically related to incontinence. At the time of admission, or if there is a change, residents will be assessed for continence status. For those residents identified has having incontinence, a toileting program will be established if possible to prevent any decline in continence status. The IDT team will review new admissions and utilize the assessments to determine individualized plans. The plans	10/16/2013

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	program to manage the resident's urinary incontinence. Review of the February 2013 MAR (Medication Administration Record) indicated the resident was receiving diuretics. Review of the resident's "ADL (Activities of Daily Living) Flow Sheet" for March 2013, indicated the resident was incontinent two times a night during the night shift, two times a day during the day shift and two to three times a day during the evening shift. Review of the March 2013 MAR (Medication Administration Record) indicated the resident was receiving diuretics. Review of the resident's "ADL (Activities of Daily Living) Flow Sheet" for April 2013, indicated the resident was incontinent two times a night during the night shift. The letter "I" indicated incontinent on day shift versus a number amount. The resident was incontinent four times a day during the evening shift. Review of the April 2013 MAR (Medication Administration Record) indicated the resident was receiving diuretics.		will then become part of the plan of care and identified on the CNA assignment sheets. Were any in-services/education provided to address deficient practice? All nursing staff was in-serviced related to preventing decline in continence status and toileting programs Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly audit 5 residents who are identified as incontinent to assure that there is a proper assessment and individualized toileting programs have been established as appropriate. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The facility utilized the current policy for training of the staff F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER It is the policy of this facility to ensure that each resident who enters the facility is not catheterized unless the clinical condition	

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	Review of the resident's "ADL (Activities of Daily Living) Flow Sheet" for May 2013, indicated the resident was incontinent two times a night during the night shift, two times a day during the day shift and two to three times a day during the evening shift. Review of the May 2013 MAR (Medication Administration Record) indicated the resident was receiving diuretics. A Quarterly MDS Assessment dated 5/7/13, indicated the resident was always incontinent. The MDS indicated the resident was not on a bladder program. Review of the resident's "ADL Flow Sheet" for June 2013, indicated the resident was incontinent two to three times a night during the night shift, two to four times a day during the day shift and three to four times a day on the evening shift. Review of the June 2013 MAR (Medication Administration Record) indicated the resident was receiving diuretics. Review of the resident's "ADL Flow Sheet" for July 2013, indicated the		demonstrates it is necessary and d any resident that is incontinent receives appropriate treatment to prevent UTI and interventions to restore normal bladder function as much as possible. I.Corrective Action Taken Related to this Finding: Resident A has been discharged from the facility. II. Other Residents with Potential to be affected by this finding will be identified by: All residents having incontinent issues have been identified through the bowel and bladder assessments and MDS assessment and internal audit . Current diagnosed with with a UTI and/or receiving antibiotics have been identified by the infection control nurse. There are no residents in the building with catheters at this time. Each one will be placed on an individual toileting program based on the assessment findings and interventions. The care plan will be revised if indicated to address the current condition determined by the care plan. Toileting will be offered no less than every two hours. Adequate hydration will be provided to decrease the risk of developing a UTI. Documentation will be kept to show progress or the lack thereof. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Each resident will be assessed for bowel and bladder function upon admission. If findings reveal the use of a catheter it will be	

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	resident was incontinent two times during the night shift. The letter "I" indicated incontinent on day shift versus a number amount. The resident was incontinent four times a day during the evening shift. Review of the July 2013 MAR (Medication Administration Record) indicated the resident was receiving diuretics. Review of the "Risk Assessment Information" (for pressure wounds and falls) dated 8/1/13, indicated the resident was often moist (once per shift) and the resident was receiving diuretics (water pill). A Quarterly MDS Assessment dated 8/1/13, indicated the resident was always incontinent. The MDS indicated the resident was not on a bladder program. A care plan for a toileting schedule to manage Resident #A's incontinence was not developed. An interview with the DoN on 9/16/13 at 9:25 a.m., indicated all residents would have a bowel and bladder evaluation upon admission. A policy for Bowel and Bladder		addressed and any treatment or interventions put in place. If there is evidence of incontinence revealed interventions will be put in place to prevent any urinary tract infections and to restore normal bladder function as much as possible. An in-service will be given to educate all staff on the procedures to be implemented to restore or maintain bladder function and address urinary tract infection prevention. Focus will be on bowel and bladder assessment and toileting programs and hydration.. IV. Corrective Actions will be monitored to Ensure Compliance by: The charge nurse will assess each resident for the initial bowel and bladder function. This information will be documented on the bowel and bladder assessment form and the information communicated to the MDS coordinator. The restorative staff along with direct care giver staff will implement the toileting program and document the results for each resident. The DON will monitor for compliance reporting to the quality assurance meeting no less than every three months. V. Completion Date *: 10-16-13	

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	Evaluation and Retraining [undated], was provided by the DoN on 9/16/13 at 9:30 a.m. The policy indicated "It is the policy of this facility to improve or maintain the residents level of bowel and bladder. Complete the evaluation for bowel and bladder retraining within 7 days. Use the gathered data to determine if the resident has retraining potential. Develop a care plan and program specific the [sic] each resident and facilitate as indicated." This Federal Tag relates to complaint number IN00133532. 3.1-41(a)(2)			

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on record review and interview, the facility failed to maintain body weight for 2 of 3 residents reviewed for weight loss. (Resident #A and #34) Findings include: 1. Resident #A's record was reviewed on 9/11/13 at 2:10 p.m. Resident #A's diagnoses included, but were not limited to, legally blind, CVA (stroke), impulse control disorder, aggression with psychosis, dementia and intermittent explosive behaviors. A Census Report dated 2/5/13, indicated the resident was to receive a No Concentrated Sweets and No Added Salt diet with evening snacks. Review of the Admission "Nutritional Assessment for MDS (Minimum Data	F000325	F 325 it is the policy of this facility to assure the nutritional status including body weight of each resident be maintained unless the condition demonstrates that this is not possible. This will be done with a therapeutic diet when there is a nutritional problem. Corrective Action Taken Related to this Finding: Resident A has been discharged from the facility. Resident # 34 has been placed on a weekly weight monitoring schedule. The dietician has been contacted to receive any recommendations regarding this matter. II. Other Residents with Potential to be affected by this finding will be identified by: All residents with significant weight gain or loss have been identified and placed on a weekly monitoring program. Dietician and physician have been notified to seek any required interventions or orders. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not	10/16/2013

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	Set) Assessment" dated 2/12/13, indicated the resident weighed 232 pounds. The form did not indicate the resident's usual body weight. Review of the March 2013 MAR (Medication Administration Record) indicated the resident had received diabetic snacks three times a day. Twelve blank areas in the MAR did not indicate if the resident was offered a snack. A physician order dated 4/5/13, indicated the resident was to have weekly weights. The resident's weight on 4/10/13 and 4/17/13 was 219, 4/24/13 weight was not recorded, 4/24/13 was 214.5. Review of the Quarterly "Nutritional Assessment for MDS Assessment" dated 5/7/13, indicated the resident weighed 233 pounds. The form indicated a 30 day weight of 227.2 pounds. Review of the May 2013 MAR, indicated the resident's weight on 5/1/13 was 233.1, 5/8/13 was 233.4, 5/15/13 weight was not recorded, 5/22/13 was 216.4, 5/29/13 weight box had a blood pressure result in it. There was lacked of documentation to indicate if the facility addressed the		recur are as Follows: Each resident will be weighed monthly. Any significant changes will be communicated to the resident and their legal representative. An in-service will be held for staff on monitoring the nutritional status or each resident. The focus will be on reporting weight gain or loss and maintaining communication of these findings communication of these finding to the dietician. IV. Corrective Actions will be monitored to Ensure Compliance by: The charge nurse will be responsible for assuring that weights are done and any significant findings are addressed and communicated to all interested parties. The DON will monitor for compliance reporting to the quality assurance no less that quarterly. V.Completion Date: *10-16-13	

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	fluctuations in weight loss/gain in regard to potential health complications. Resident #A was sent to the hospital on 6/5/13 and returned on 6/6/13 due to behaviors. There were no orders to discontinue or resume weekly weights. The July 2013 MAR indicated the resident had received diabetic snacks three times a day. Nine blank areas in the MAR did not indicate if the resident was offered a snack. 2. Resident #34's record was reviewed on 9/16/13 at 10:30 a.m. Resident #34's diagnoses included, but were not limited to, depression, dementia, hypertension, and tachycardia (fast heart rate). Physician order dated 6/17/13, indicated Pro Stat (protein supplement with 101 calories) 101, 30 ml (milliliters) by mouth twice a day. Physician order dated 6/29/13, indicated Pro Stat 101, 90 ml by mouth twice a day. 7/16/13 dietary quarterly indicated the resident have not had a weight loss of 5% or more in the last month. The			

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	resident's weight at this time was 198 pounds. Indicated 30 day weight was 197 pounds and 180 day weight was 200.4 pounds. The RD (Registered Dietician) note indicated the resident's intake was 50% to 76% of meals, the resident would receive extra calories with med pass. The RD requested 2 Cal (dietary supplement to help gain or maintain weight) to be discontinued and was no longer needed. Resident #34 went to the hospital emergency room for an evaluation due to mental status changes and pain upon voiding on 8/12/13. The resident returned to the facility on 8/13/13. Review of the August 2013 TAR (Treatment Administration Record) indicated weekly weight was started on 8/15/13. The resident's weight on 8/15/13 was 181.2 pounds. There was not a weight recorded on 8/21/13. The resident's weight on 8/28/13 was 180 pounds. Review of the resident's monthly weights indicated the resident had a 18.6 pound significant weight loss from 3/5/13 (198.6 pounds) to 9/9/13 (180 pounds). The resident had an 18 pound weight loss from 6/5/13 (198 pounds) to 9/9/13 (180 pounds)			

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	and a 7.4 pound weight loss from 8/5/13 (187.4) to 9/9/13 (180 pounds). The nutritional care plan updated on 9/9/13, indicated the resident had fluctuating weight and was obese. Interventions indicated 90 ml 2 cal twice a day with med pass, 90 ml Protstat twice a day with med pass, snacks between meals, per request, ensure or ensure pudding at supper. There was no date to indicate when the interventions were initiated. Physician order dated 9/9/13, indicated to discontinue the previous diet. The order indicated "new regular diet. See speech therapy due to resident spitting out food in bag." An interview with the Registered Dietician on 9/10/13 at 10:00 a.m., indicated the resident should lose weight and the doctor agreed. There was no order or intervention indicating a weight loss plan. An interview with the MDS Coordinator on 9/17/13 at 9:50 a.m., indicated she updates care plans as she received orders. The MDS Coordinator indicated the dietary department was responsible for their care plans. The MDS Coordinator indicated she had to "dig" in the			

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	resident charts to be able to determine if the interventions were effective. The MDS Coordinator indicated there was no communication with staff regarding the interventions. This Federal Tag relates to complaint number IN00133532. 3.1-46(a)(1)			

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F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review and interview, the facility failed to ensure residents receiving antipsychotic medications were assessed for non-pharmacological interventions and risk verses benefit of medications for reducing maladaptive symptoms/behaviors. The facility failed to ensure an appropriate indication for use of an antipsychotic medication, and failed to monitor for side effects, efficacy, continued need for antipsychotic	F000329	. F 329 Unnecessary Medications It is the policy of the facility to assure that each resident's drug regimen is free from unnecessary drugs. Corrective Action Taken Related to this Finding: Resident # 16 and #41 are being reviewed in behavior management meeting to evaluate the need for continuing their psychotropic meds or the need for a gradual dose reduction. The care plan was reviewed and revised after both were assessed for non-pharmacological interventions.	10/16/2013

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	medications and gradual dose reduction attempts for 2 of 4 residents reviewed for unnecessary medications (Residents #16 and #41). Findings include: 1. The following observations were made of Resident #16: 09/11/2013-Constant observation from 9:40 A.M. until-10:40 A.M.- Sitting in a wheel chair in the activity room with her head down, drooling, eyes closed, and her tongue protruding in and out of her mouth. Other residents were observed in the room and staff was observed in and out of the room. The television was on. During this time Resident #16 did not arouse. 9/12/2013 at 3:22 P.M. - Resident #16 rocked back and forth in a wheel chair in the activity room. She had repetitive protrusion of her tongue from the mouth and her eyes were closed. 9/12/2013 at 4:00 P.M. - Resident #16 remained in the same location as above. She had her hands partially over her face. She continued to rock back and forth. Her tongue continued to protrude in and out of her mouth.		II. Other Residents with Potential to be affected by this finding will be identified by: All residents receiving antipsychotic medications have been identified and their medication regimen reviewed for any unnecessary medication by the pharmacy consultant. MDS will assess and the care plans will be revised to include any non pharmacological interventions indicated. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All residents receiving antipsychotic medication will be reviewed at the monthly behavior management meeting by a multidisciplinary healthcare team to determine the need of these medications or indications for a gradual dose reduction, discontinuance of these meds or non- pharmacological intervention. This team includes the medical director, social service, psychologist, pharmacy, DON, MDS. These reviews will take place no less than quarterly and more often if needed. The recommendations will be made by the physicians in attendance at the meeting and communicated to the resident's personal attending physician for the final order. Pharmacy In service held by 10-16-13 with nursing staff to address what constitute unnecessary medications and other interventions that should be implemented to address behavior	

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	Her eyes were closed. 9/13/2013 at 9:50 A.M., 10:00 A.M. 10:15 A.M., 10:30 A.M.,11:00 A.M., 11:30 A.M., and 2:38 P.M.- Resident #16 rocked back and forth in a wheel chair in the activity room. Her eyes were closed. Her tongue continued to protrude in and out of her mouth. She put her hands on and off of her face. 9/13/2013 at 12:35 P.M., CNA (Certified Nursing Assistant) #2 was observed to feed Resident #16. Resident #16's eyes were closed and she rocked back and forth. When the silverware was put to her mouth she would open her mouth and take the food. Otherwise her tongue protruded in and out of her mouth. During an interview at this time, CNA #2 was queried if Resident #2 ever opened her eyes. CNA #2 replied, "She opens her eyes sometimes." Resident #16's record was reviewed on 9/16/2013 at 9:25 A.M. Resident #16 had diagnoses which included, but were not limited to, dementia with behaviors, Alzheimer's disease, and syncope and collapse. A quarterly MDS (minimum data assessment tool) dated 07/30/2013,		problems. The interdisciplinary team reviews the unnecessary medications daily at the morning managers meeting. The Alpha Home has also implemented the daily follow up for reporting form for communication to physician. These practices have been implemented to ensure the deficient practice does not recur. Additionally, residents' independent choices are reflected in the care plan with involvement from the resident's POA. The quality assurance team will assist with monitoring for follow up with unnecessary medication IV. Corrective Actions will be monitored to Ensure Compliance by: 10-16-13 The nursing staff and behavior management will be responsible for the management of use of antipsychotic meds in the facility. The Director of Nursing service will monitor for compliance. Noncompliance reporting and finding submitted to the Quality Assurance at its regular scheduled monthly meeting. This practice will be on going for the next three months. The Quality Assurance Committee will review and make recommendation for continuous quality improvements, for the next quarter with the committee will determining if additional recommendation is necessary. V. Completion Date:10-16-13	

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	indicated Resident #16 received an antipsychotic medication, had dementia and Alzheimer's disease, did not have a condition which resulted in a life expectancy less than six month, and had gained 11 pounds in the last 180 days (a 6.4% gain). A care plan originally dated 5/21/2010 and last updated 8/30/2013, indicated Resident #16 was at risk for behaviors, agitation, verbal or physical aggression due to the diagnoses of dementia with agitation, behaviors, delusions, dementia with verbal and physical aggression, and Alzheimer's disease. The goal set for Resident 16 indicated, "Resident will have no behaviors AEB (as evidenced by) no verbal or physical aggression daily." Approaches to meet this goal included, "medications as ordered on Zyprexa, monitor for behaviors or moods and document, refer to psych services and behavior management for changes in mood or behavior, and consult with MD (medical doctor) for changes." A care plan originally dated 5/21/2010, and last updated on 8/30/2013, indicated, "Problem: Resident has DX (diagnosis) of anxiety and risk for s/s (signs and symptoms) anxiety. Goal: Resident			

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	will have no episodes of anxiety. Approach: Monitor for s/s anxiety I.E. (for example) restlessness, changes in cognition, etc, consult with MD for changes, refer to psych services and behavior management, take to room and provide quiet environment to assist with calming resident." A current care plan originally dated 5/21/2010 and last updated on 8/30/2013, indicated, "Problem: Risk for side effects from the antipsychotic medication Zyprexa. Goal: Resident will have no side effects from the medication I.E. dry mouth, headache, falls, constipation, indigestion. Approach: Medication as ordered, monitor labs as ordered, monitor for side effects and document, consult with MD for changes, consult with Psych services or behavior management for changes in mood or behavior, AIMS test every 6 months." A social service MDS supportive document tool dated 8/22/12, indicated Resident #16 had trouble with concentration. The record indicated, "...There are no moods or behavior noted during this reference period...." An untimed physician's note, dated 9/13/12, indicated Resident #16's			

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	daughter was concerned about her mother falling out of bed, she exhibited increased agitation as evidenced by pulling out her hair. The physician ' s note indicated Zyprexa (antipsychotic medication) 5 mg (milligrams) was discontinued on 6/20/2012. The note indicated a new order for Zyprexa 2.5 mg every evening and indicated, " question any irritation of scalp or behavior which is now more prominent now with d/cing (discontinuing) of Zyprexa." An untimed physician's progress note dated 10/4/12, indicated Resident #16's daughter had called the office and reported her mother had rolled out of bed, pulled her hair out, and requested an evaluation of her medications to see if it was a side effect of her medications and if so if there was another medication that could be used. This note indicated the facility told her this was due to agitation. An untimed psychological consultation note dated 10/17/2012, indicated Resident #16 was evaluated, she was alert and oriented to self only, "...periods of signs of auditory hallucinations. Patient with decreased agitation and spitting episodes. Patient with expressive			

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	language deficit...." An untimed social service note dated 10/23/2013, indicated, "(Resident #16 named) was seen by Doctor (name given) for psych. consult. No new recommendations, updated diagnosis of dementia of the Alzheimer's type with behavioral disturbances, psychotic disorder..." An untimed social service MDS supportive documentation tool dated 11/15/12, indicated, "...When asked questions she continued to fidget in chair and pull o [sic] her hair to extent that writer could see some hair on her finger. Per staff this behavior is no new. Resident was seen by psych services 10/23....Appetite is poor and receives 2 Cal supplement 4 times a day as a prevention for potential weight loss....Olanzapine 2.5 mg (Zyprexa) for agitation/behaviors." An untimed psychological progress note dated 1/7/2013, Resident #16 was reviewed to assess current levels of signs and symptoms of psychosis and agitation. This note indicated, "...Patient was alert and oriented to self. Patient with significant expressive language deficits. Patient with decreased agitation episodes. Presence of risk factors (harm to			

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	self/others, psychotropic side-effects: None...." An untimed social service MDS supportive documentation tool dated 2/8/13, indicated, "...(Zyprexa) .5 mg is given 1 X a day for agitated behaviors. Resident did not make eye contact or even look in writers direction when addressed by name. she continued to keep her head down and her eyes closed but was not asleep. She picked at her hair throughout the assessment. She received a daily dietary supplement as a weight loss prevention due to poor consumption. She lacks the ability to focus on any assigned or specific task such as watching t.v., reading or even looking at a newspaper. Resident is in own world and this status is not new. She is followed by psych services for medications and behaviors." An untimed physician's progress note dated 2/14/2013, indicated Resident #16 was being evaluated for dementia. This note indicated Resident #16 aroused to light touch and name being called and staff reported no current issues. An untimed social services MDS supportive documentation tool note			

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	dated 5/1/13, indicated, "...for agitation she gets Olanzapine 2.5 mg (Zyprexa).... During today's assessment (Resident #16 named) was inattentive her eyes remained closed as she rocked back and forth and picked at her hair.... (Resident #16 named) does not watch t.v. is on or when it is off. She is in her own world...." An untimed psychology progress note dated 5/1/2013, indicted Resident #16 was evaluated to assess her current levels of symptoms of psychosis and agitation. This note indicated, "Patient was alert and oriented to self. Patient with decreased agitation episodes and delusional signs of psychosis.... Presence of risk factors (harm to self/others, psychotropic side-effects): None...." An untimed psychology progress note dated 7/26/13, indicated Resident #16 was evaluated to assess her current levels of symptoms of psychosis and agitation. This note indicated, "Patient was alert and oriented to self. Patient with decreased agitation episodes and signs of psychosis.... Presence risk factors (harm to self/other, psychotropic side effects): None...."			

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	A pharmaceutical consultation report dated August 12, 2013, indicated Resident #16 had dementia and received an antipsychotic Zyprexa 2.5 mg every evening. This note recommended, "Please consider reducing the dose of Olanzapine (Zyprexa to 2.5 mg every other bedtime, with the eventual goal of discontinuation, while concurrently monitoring for re-emergence of target and/or withdrawal symptoms.... Physician's response: I accept the recommendation(S) above, please implement as written. D/C Olanzapine 2.5 mg po at HS. Start Olanzapine 2.5 mg po (orally) every other night. Staff to document any changes in behavior and or mood." AIMS (Abnormal Involuntary Movement Scale) assessments, dated 9/19/12, 11/16/12. 2/8/13, and 5/1/13. indicated Resident #16 did not exhibit abnormal tongue movement or abnormal trunk movement (rocking). An AIMS, dated 7/30/13, indicated Resident #16 did not exhibit abnormal tongue movement but did exhibit "mild" abnormal trunk movements During an interview on 9/16/2013 at 10:32 A.M. LPN #3 indicated Resident #16 had been "doing that thing with her tongue" ever since she			

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	lived there. During an interview on 9/16/2013 at 2:30 P.M., with the DON (Director of Nursing), SSD (Social Service Director), and the Administrator present, documentation regarding the use of Zyprexa for Resident #16, including pharmacy recommendations and the following documentation for Resident #16 was requested: the original date Zyprexa was ordered and at what dose, all AIMS assessments, all GDRs (gradual dose reduction), all pharmacy recommendations resulting from medication reviews, physician documentation which indicated an assessment of the risk versus the benefits of the medication, indication that continued use of Zyprexa was a valid therapeutic intervention for Resident #16, documentation the facility's interdisciplinary team ensured that the care plan included: ongoing monitoring of specific target behaviors; documentation which included Resident #16's behaviors were a threat to herself or others and nonpharmacological options had failed, the desired outcome from the use of Zyprexa, the efficacy of individualized, non-pharmacological approaches, and the potential adverse consequences of Zyprexa.			

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	The facility's policy on psychotropic drug use was requested at this time. During an interview on 9/17/2013 at 10:30 A.M., the MDS/Care plan coordinator stated, "When she (Resident #16 named) first came here she was up twirling and dancing." The MDS coordinator indicated she was responsible for completion the AIMS (Abnormal Involuntary Movement Scale) assessments. The MDS coordinator indicated her assessments were inconsistent because she did not consult the staff who cared for Resident #16 when she evaluated her for potential adverse affects from the use of antipsychotic medications. She indicated she documented what she saw at the moment of the AIMS assessments. During an interview on 9/18/2013 at 1:05 P.M., the DON indicated she did not have an explanation as to why GDRs were not attempted prior to 8/20/13, or an explanation why potential antipsychotic medication side effects were not addressed when documented. addressed. At this time the DON stated, "This whole reduction with psych meds for dementia residents just started." During an interview on 9/17/2013 at			

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	1:45 P.M., with the MDS coordinator, the SSD, the DON, and the Administrator present, the Administrator indicated Resident #16's hair is dry and they have considered this to be a cause of her pulling at her hair. 2. Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Resident #41 was admitted to the facility on October 7, 2012 and had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, constipation, anemia, a history of a stoke with left sided weakness, a recent urinary tract infection (UTI), psychosis, and seizures. Resident #41's admission orders indicated he was admitted with orders for Zyprexa (antipsychotic) 5 mg (milligrams) daily. MDS (minimum data set assessment tool) dated, 3/28/13 (quarterly MDS), 4/3/13 (discharge with return MDS), 4/19/13 (significant change MDS), 4/25/13 (14 day MDS), 6/10/13 (60 day MDS), and 7/1/13 (quarterly MDS) indicated Resident #41 did not exhibit behaviors. The MDS assessments indicated Resident #41 was cognitively intact with a BIMS (brief interview mental status cognition assessment tool) score of 14:15.			

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	A care plan originally dated 10/8/2013, and last updated on 8/20/2013, indicated Resident #41 had a diagnosis of psychosis and was on an antipsychotic medication. The care plan indicated a goal of no changes in mood or behavior daily. Approaches listed included: 1) Give medications as ordered. Resident is on Zyprexa 5 mg daily. 2) Monitor for changes in mood or behaviors and document. 3) Encourage Resident #41 to voice his feelings and document. 4) Consult with psych services and doctor as needed. A care plan originally dated 11/1/2012, and last updated 8/20/2013, indicated Resident #41, "Res (resident) calling staff names et (and) cursing, refusing meds et refusing care, res wants staff to adjust his exdwelling catheter @ X's (at times) or manually assist w/evacuation (with evacuation) of BM's (bowel movements) @ (at) times. Goal: Resident will not have inappropriate behaviors daily. Approaches: 1. Encourage not to call names or curse. 2. Explain that we are here to care for him. 3. Explain consequences of not getting cleaned up i.e. bed sore smelling etc. 4. Consult w/MD (with medical doctor) as needed."			

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	Interdisciplinary notes (IDT) were reviewed dated from 1/2013 through 9/2013. An IDT note dated 2/5/2013, indicated Resident #41 admitted he had refused showers because of the "cold weather." An IDT note dated 2/12/13, indicated, "show some impulsive behavior on 2/10/13 by trying to run over someone w/ w/c (with a wheel chair).... " An IDT note dated 6/10/2013 indicated, "verbally abusive and threatening to staff. Calling inappropriate names. Making false statements. Recommend to referral to psych services. Continue to observe for change." An IDT note dated 7/8/2013, indicated, "Reviewed in behavior management. Res (resident) on Zyprexa. Needs psych referral to see (Dr. Named). Continue to observe for change." Behavior monitoring sheets for June, July, and August 2013 were reviewed. The records indicated Resident #41 was monitored for the following behaviors: 1) Refused medications and care. 2) Argued with staff. The record indicated Resident #41 did not			

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	exhibit behaviors during the months of June, July, and August 2013. The record indicated Zyprexa was prescribed for psychosis. The behavior record lacked documentation of symptoms of Resident #41 ' s psychosis to be monitored and tracked for patterns. Resident #41's record lacked documentation of psych consults, GDRs, pharmacy recommendations in regards to the use of antipsychotic medication, documentation of psychotic behaviors, assessments of the risks versus the benefits of anti-psychotic medications use, evaluations which determined the need for continued use of Zyprexa, or documentation of the efficacy of Zyprexa. During an interview on 9/17/2013 at 1:45 P.M., with the MDS coordinator, the SSD, the DON, and the Administrator present, the following information for Resident #41 was requested: 1) Indications for the use of Zyprexa 2) Physician's orders and assessments regarding the Zyprexa. 3) Documentation of behavior monitoring 4) Psychiatric consultations. 5) Pharmacy reviews and recommendations regarding the use of Zyprexa. 6) Care plans			

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	regarding the use of Zyprexa. 7) Gradual dose reductions (GDRS). 8) Any and all documentation of behaviors, interventions implemented, and evaluations of the efficacy or lack thereof with attempts of non-pharmacological interventions implemented. During an interview on 9/18/2013 at 1:05 P.M., the DON indicated in regards to the information requested for Resident #41, "I don't have anything more to provide to you. You have all we have." A policy current policy titled "Unnecessary Drugs" dated '2005,' provided by the DON on 9/16/2013 at 9:30 A.M., indicated, "...Purpose: To outline, define, and maintain the facility's policy as it relates to unnecessary drugs, so as to ensure the resident's drug profile is free of any unnecessary drugs.... Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (1) In excessive dose (including duplicate therapy). (2) For excessive duration. (3) Without adequate monitoring. (4) Without adequate indications for its use. (5) In the presence of adverse consequences which indicate the			

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	dose would be reduced or discontinued. (6) Any combination of the above.... Monitoring for antipsychotic drug side effects: The facility assures that residents who are undergoing antipsychotic drug therapy receive adequate monitoring for significant side effects of such therapy with emphasis on: (1) tardive dyskinesia (2) postural orthostatic hypotension (3) cognitive impairment (4) akathesia) (5) parkinsonism. When antipsychotic drugs are used without monitoring for these side effects, they may be unnecessary drugs because of inadequate monitoring." An undated current facility policy titled "GDR POLICY" provided by the DON on 9/7/2013 at 1:46 P.M., indicated, :It is the policy of this facility to maintain a residents behavior and psychosocial needs on the lowest dose of psychotropic medication necessary In order to do this the psychotropic medication regimen is reviewed no less that every quarter to attempt a GDR, Gradual dose reduction in their medication. The resident's care plan, nurses notes, behavior documentation medication regime along with any other significant data are discussed by the interdisciplinary behavior			

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	management team including but not limited to: Medical director, Pharmacy consultant, MDS coordinator, Social services, Executive director, Director of nursing, Psychologist. A recommendation is made to address the possibility or the lack thereof to adjust the resident's medication. This is then communicated to the attending physician who will make the final decision. This policy is in compliance with Indiana Health Facilities Licensing and Operational Standards." 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(b)(2)			

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F000334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.			
	Based on interview and record review, the facility failed to ensure residents and/or their representatives were provided with the VIS (Vaccine Information Statements) education produced by the CDC (Center for Disease Control) which explained both the benefits and risks of the vaccinations so informed decisions regarding the acceptance or declination of the flu vaccination and/or pneumococcal vaccination could be made. This deficient practice affected 5 of 5 residents reviewed for vaccinations (Resident #41, #30, #47, #33, and #16).	F000334	F334 Were other residents identified with potential to be affected by the deficiency? All residents that have received the flu vaccine have received the appropriate education recommended by the CDC. This information is documented in the medical record What measures and systemic changes were put in place to assure deficient practice does not recur? All nurses have been in-serviced related to utilizing the appropriate educational information prior to administering the flu vaccine. The information utilized will be the recommended information from the CDC. This will continue	10/16/2013

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	Findings include: 1. Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Immunization records indicated, Resident #41 was administered the flu vaccination on 10/8/2012 and administered the pneumococcal vaccination on 12/7/12. His record lacked documentation the VIS education was provided to him or his family. 2. Resident #30's record was reviewed on 9/13/2013 at 2:11 P.M. Immunizations records indicated Resident #30 was administered the flu vaccination on 10/18/2012, and administered the pneumococcal vaccination on 1/13/2013. Her record lacked documentation the VIS education was provided to him or his family. 3. Resident #47's record was reviewed on 9/17/2013 at 9:20 A.M. Immunizations records indicated Resident #47's legal representative declined both the flu and pneumococcal immunization. Her record lacked documentation the VIS education was provided to him or his family. .		throughout the current flu season. Any new residents that require the flu vaccine will be provided the proper educational information prior to the administration of the vaccine. This will be documented in the medical record Were any in-services/education provided to address deficient practice? Nurses were in-serviced on the appropriate informational information that is to be provided to any resident prior to their decision to receive the flu vaccine. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly audit 5 residents who are identified to have received the flu vaccine. This tool will review to assure that there is appropriate documentation that the recommended educational material was provided to the resident. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to	

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	4. Resident #33's record was reviewed on 9/13/2013 at 2:11 P.M. Immunization records indicated Resident #33 was administered the flu vaccination on 10/19/2012, and administered the pneumococcal vaccination on 12/7/12. His record lacked documentation the VIS education was provided. 5. Resident #16's record was reviewed on 9/16/2013 at 9:25 A.M. Immunization records indicated Resident #16 was administered the flu vaccination on 10/17/2012, and administered the pneumococcal vaccination on 8/20/13. Her record lacked documentation the VIS education was provided. During an interview on 9/18/2013 at 11:46 A.M., the infection control nurse indicated the only education she provided to residents and/or a family regarding the vaccinations was the risk of developing an elevated temperature and the immunizations did not guarantee they would not get the illness but the symptoms would be less severe. She indicated she was not aware of the CDC's (Center for Disease Control) guidelines and state laws which required the VIS information be provided to residents or families prior to their acceptance or		address the deficient practice? The facility reinforced the current policy of flu vaccines as part of the training Reason for IDR F 334 INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS IT IS THE POLICY OF THIS FACILITY TO PROVIDE EDUCATION TO RESIDENTS AND THEIR LEGAL REPRESENTATIVE REGARDING INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS I.Corrective Action Taken Related to this Finding: Resident #41 has been educated regarding the Influenza and Pneumococcal vaccines. His legal representative has also been educated on the benefits and side effects if the immunizations. The legal representatives for resident #32#,47#,33 and #16 have been educated on the side effects and benefits of influenza and pneumococcal immunization. This information will be the VIS guidelines provided by the CDC. . II. Other Residents with the potential to be affected by this finding will be identified by: All residents in the facility are identified as being affected by this finding and the resident ans/or their legal representative will be offered education regarding the benefits and side effects if the pneumococcal and influenza immunizations. The education will be derived from the VIS documents provided by the CDC.	

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	declination of immunizations. The DON was present for this interview and indicated the facility to not provide education to residents or families beyond what the infection control nurse had indicated. A current policy dated 7/12, and titled "Influenza and Pneumococcal Immunization" provided by the infection control nurse indicated, "...It is the policy of the Alpha Home to ensure that before offering the influenza and pneumococcal immunizations each resident or their legal representative is provided education regarding the risks and the benefits of the immunization. This must include the potential side effects of the medications. Annual documentation of this education for influenza immunization must be maintained in a clinical record along with documentation of whether or not the resident accepted or refused the medication. The same must be done for pneumococcal immunization as indicated...." 3.1-18(b)(5)		. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: An inservice will be held to educate staff on the policies and procedures to be followed related to influenza and pneumococcal immunizations Discussion will focus on the education of residents and legal representatives provided by VIS from CDC prior to medication administration. IV. Corrective Actions will be monitored to Ensure Compliance by: The infection control nurse will be responsible for assuring that these policies and procedures be carried out with each resident; The DON will monitor for compliance and report no less than quarterly to the quality assurance committee. V. Completion Date *1O-16-13 This finding was reviewed in 2012, accepted and placed back in compliance. We have consistently used this protocol to inform our residents and their legal responsible representatives with education regarding influenza and pneumococcal immunization.	

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F000353 SS=G	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on record review and interview, the facility failed to ensure there was sufficient nursing staff and related services to prevent decline in a resident's ability to ambulate and a decline in strength and ability to transfer for 3 of 5 residents reviewed for restorative services (Resident #41, #32, and #28) Findings include: 1. Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M.	F000353	F353 Were other residents identified with potential to be affected by the deficiency? All residents that have orders for therapy or who are identified to be on restorative programs are currently receiving those programs appropriately. There is designated restorative personnel that are not pulled into regular nursing staffing. The facility has a current Therapy provider that is providing services to all residents with therapy orders. What measures and systemic changes were put in place to assure deficient practice does not recur?	10/16/2013

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	Resident #41 had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, anemia, a history of a stoke with left sided weakness, a recent urinary tract infection (UTI), and seizures. A five day significant change Minimum Data Set Assessment Tool (MDS) dated 4/19/13, indicated Resident #41 was re-admitted to the facility on 4/12/2013, after being discharged from an acute care hospital, where he received treatment for an UTI. This MDS indicated Resident #41 was cognitively intact with a BIMS (brief interview mental score cognition assessment tool) score of 14:15, totally dependent on the assistance of one staff for locomotion, dressing, personal hygiene, bathing, transfers, toileting, and had received physical therapy and occupational therapy. During an observation on 9/10/2013 at 2:29 P.M., Resident #41 was observed sitting in his wheel chair in his room. Resident #41 had a therapeutic glove on his left hand/arm and leaned to the left in the wheel chair. An un-timed physician's order dated 6/10/2013, indicated, "Late entry for 6/3/2013, extend skilled PT (physical		The facility has a new Therapy provider and all therapy services are being provided in accordance with the physician's order. The Administrator is responsible for assuring that a therapy contract remains in place and that the therapy services ordered by the physician are in place. The Restorative personnel are now separate from the CNA staffing and will not be pulled to the floor to work in a position other than restorative on restorative scheduled days. The Staffing Coordinator has been in-serviced to assure that the restorative position is present on each day. Were any in-services/education provided to address deficient practice? The staffing coordinator was in-serviced related to assuring that restorative is not pulled into regular CNA staffing. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly audit 5 residents who are identified to have orders for therapy services or restorative programming. The tool reviews presence of therapy and restorative documentation to assure that the therapy and restorative program are followed appropriately. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed	

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	therapy) 5/wk (week) X 6 wk for therapy exs (exercises) ble (bilateral extremities), therapy activity... gait transfer training modalities as indicated to improve functional mobility." A physical therapy weekly summary note dated 6/24/2013-6/28/2013, indicated Resident #41 was able to ambulate, with minimum to moderate assist, thirty feet with two repetitions per session, required minimum assistance to sit up from a flat position and to stand from a sitting position, and was independent with wheel chair mobility. This PT note indicated, "Pt (patient) is improving toward all goals of gait/transfers/balance and strength. Rehab (rehabilitation) potential is good. Cont (continue) tx (treatment) as tolerated to achieve long term goals...." A telephone order dated 7/2/2013-4:00 P.M., indicated, "Late entry for 6/28/2013 d/c (discontinued) from skilled ot/pt (occupational therapy/physical therapy) at maximal functional level " This order indicated the facility was to provide restorative services six days a week for six weeks beginning 7/8/2013. These restorative services were to include		appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy was utilized for training. No newly developed policy was needed. F353 Were other residents identified with potential to be affected by the deficiency? All residents that have orders for therapy or who are identified to be on restorative programs are currently receiving those programs appropriately. There is designated restorative personnel that are not pulled into regular nursing staffing. The facility has a current Therapy provider that is providing services to all residents with therapy orders. What measures and systemic changes were put in place to assure deficient practice does not recur? The facility has a new Therapy provider and all therapy services are being provided in accordance with the physician's order. The Administrator is responsible for assuring that a therapy contract remains in place and that the therapy services ordered by the physician are in place. The Restorative personnel are now separate from the CNA staffing and will not be pulled to the floor	

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	therapeutic exercises to all extremities, left hand splint, and ambulation with platform rolling walker. A restorative nursing program therapy referral form dated 7/8/2013, indicated Resident #41 needed the following restorative programs: ROM (range of motion) exercise, splinting, and ambulation. Problems: 1) Decreased active mobility LUE (left upper extremely). 2) Decreased strength LLE (left lower extremely). 3) Decreased ambulation skills. 4) Decreased transfer skills. Precautions: Fall Risk. Resident's functional status upon d/c (discontinue) from therapy: Ambulation with PRW (platform rolling walker) x 50 feet with min (minimum) A (assist) of 1, transfers with min A of 1 using small steps, strength fair... LU/LE (left upper/lower extremities), splint with edema-glove to L(left) hand/wrist. Program goals: 1) Ambulate with PRW X 75 feet with min A of 1. 2) Decrease edema in L hand. 3) Transfer with CGA (contact guard assist) min A of 1 using small steps. 4) Increase strength LLE (left lower extremities) to fair. Instructions included: 1) PROM (passive range of motion) to left upper extremities with support to his shoulder, massage		to work in a position other than restorative on restorative scheduled days. The Staffing Coordinator has been in-serviced to assure that the restorative position is present on each day. Were any in-services/education provided to address deficient practice? The staffing coordinator was in-serviced related to assuring that restorative is not pulled into regular CNA staffing. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly audit 5 residents who are identified to have orders for therapy services or restorative programming. The tool reviews presence of therapy and restorative documentation to assure that the therapy and restorative program are followed appropriately. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy was utilized for training. No newly	

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	hand and position in splint. (Monitor splint during the day), 2) Ambulation in //(parallel bars) PRW with min (minimum) assist of 1) PRW additional sup (support) to follow with wc (wheel chair). 3) AAROM/AROM (active range of motion) exs (exercise) to BLE (bilateral lower extremities) in sitting at 25/reps (repetition)/ each, bike X 15 minutes.... Special equipment: PRW. Start Date 7/8/ 2013. Frequency and Duration 6/wk X 6 wks (8/30/2013).... Copies given to (1) Therapist, (2) Restorative aide, (3) original in chart." Range of motion program records dated July, August, and September 2013, indicated, "Daily Program Documentation for Restorative/Rehabilitation Nursing.... Goals: 1. Ambulate with personal roller walker at 75 feet with minimal assist of one. 2. Decrease edema in left hand. 3. Transfer with contact guard assist min (minimum asst of one using small steps. 4. Increase strength left lower extremities to fair. Programs: ambulation, ROM, splint/brace training...." These records indicated: Week 1: July 8-14, 2013, Resident #41 received restorative ambulation		developed policy was needed. Reason for IDR After checking the resident roster and the Resident Stage 2 Sample List submitted by the ISDH surveyors no resident could be identified as #2. F 353 SUFFICIENT 24 HOUR NURSING STAFF PER CARE PLANS It is the policy of the Alpha Home to have sufficient nursing staff to provide and maintain the highest practicable level of physical, mental, and psychosocial well being as determined by the residents' assessments and individual care plans. I.Corrective Action related to this finding: The restorative has been re-scheduled to only provide restorative services. A new order for a PT/OT evaluation has been obtained for resident # 41.Resident #32 has been discharged from therapy and restorative has been resumed. Resident #28has resumed therapy. II. Other Residents with Potential to be affected by this finding will be identified by: All residents receiving therapy or restorative care are identified as being affected by this policy. According to our resident roster we are unable to identify resident #2. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Sufficient staffing will be provided daily to assure that residents receive proper care and that restorative services are not	

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	services one day out of seven (July 12). The record lacked documentation ROM restorative services were provided this week. The record indicated Resident 41's progress for that week was, "Not any." Week 2: July 15-21, 2013, Resident #41 received restorative ambulation and ROM services two out of seven days (July 17 and 18). The record indicated Resident 41's progress for that week was, "Not enough." Week 3: July 22-28, 2013, Resident #41 received ambulation and ROM restorative services five out of seven days (July 22, 23, 26, 27, and July 28). The record indicated Resident 41's progress for that week was, "Not enough." The record lacked documentation splint/brace training services were provided during the month of July 2013. Week 4: July 29-August 4, 2013, the record lacked documentation which indicated Resident #41 received ambulation, ROM, or splint/brace training restorative services. The record indicated Resident 41's progress for that week was, "Not		interrupted. IV. Corrective Actions will be monitored to Ensure Compliance by: The staffing coordinator will assure that adequate staffing is scheduled daily. The restorative staff will be scheduled and maintained separately from the direct care C.N.A. staff. The DON will monitor for compliance. Reports will be made to the quality assurance committee no less than quarterly . V. Completion Date: *10-16-13	

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	enough." Week 5: August 5-11, 2013, Resident #41 received restorative ambulation, ROM, and splint/brace training services two out of seven days (August 6 and 7). The record indicated Resident 41's progress for that week was, "Not enough restorative this week." Week 6: August 12-18, 2013, Resident #41 received ambulation restorative services and ROM services six times during the week (August 12, 12, 14, 15, 16 and August 17), and brace/splint training services four out of seven days (August 12, 13, 14, and August 15). The record indicated Resident 41's progress for that week was, "Patient did good with Range of motion." The record lacked documentation of his ambulation progress. Week 7: August 19-25, 2013, Resident #41 received ambulation and ROM restorative services six days August 19, 20, 21, 22, 23, 24, 2013). The record lacked documentation resident #41 received splint/brace training services this week. The record indicated Resident 41's progress for that week was, "Patient able to move the right side of			

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	limbs." The record lacked documentation of his ambulation progress. Week 8: August 26-September 1, 2013., Resident #41 received ambulation and ROM restorative services five out of seven days (August 26, 27, 29, 30, and August 31). The record lacked documentation brace/splint training services were provided during this week. The record indicated Resident 41's progress for that week was, "Patient doing good with ROM and can still move the right side." The record lacked documentation of his ambulation progress. This record indicated from September 2-7, 2013, Resident #41 received ambulation restorative services five out of seven days on September 3, 4, 5, 6, and September 7. The record lacked documentation which indicated Resident #41 received ROM or brace/splint services during this week. The record indicated Resident 41's progress for that week was, "Patient can move right side of limbs, but need help with left." The record lacked documentation regarding his ambulation status. A current care plan updated on			

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	8/20/2013, indicated Resident #41 was at risk for falls due to a diagnosis of a stroke and left sided hemi-paresis. The goal listed was Resident #41 would not have falls or injuries from falls. Interventions listed to meet this goal included staff were to encourage him to attend and participate in therapy. During an interview on 9/13/2013 at 11:19 A.M., Restorative Certified Nursing Assistant (RCNA) #1 indicated she had been providing Resident #41 with "Basically ROM." RCNA #1 stated, "He can't move his right side. We had the bars in the room. We would stand him up but they are gone." RCNA indicated she didn't know how long the bars had been gone. She indicated she did not work with Resident #41 until therapy left. RCNA #1 stated, "She told me if I could have help- stand him up. Basically, what I did was ROM until I felt he was strong enough to stand up. When I had the bike I would put him on the bike. It's all passive. I've never seen him walk. I never walked him out of the parallel bars because of safety. That's where I felt comfortable with his chair behind him. We only did it four or five times over two week time.... They gave me the paper July 8. It was on my desk. By			

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	the time I wrote it up. I was on the floor. Short of help by the time I got it started. Don't know exactly .... " RCNA #1 indicated she was the only RCNA and couldn't provide the restorative services recommended by therapy. RCNA indicated she was pulled to the floor to work as a CNA (certified nursing assistant) because the facility did not have enough staff. During a telephone interview on 9/19/2013 at 4:15 P.M., PRP Physical Therapist #2 indicated Resident #41 was evaluated the day he was made aware of the order. His evaluation indicated Resident #41's current status was, "A max assist to ambulate 15 to 20 feet at the most with a platform walker and physical assistance. His transfer ability is moderate. His sit to stand ability is moderate. His static dynamic balance is poor with max assistance. He is a high risk for falls and if he attempted to stand, walk, or reach for something without max assistance and a platform walker, he would fall." PRP Physical Therapist indicated his evaluation indicated Resident #41's status had declined since the last status recorded by the previous therapy company. 2. Resident #32's clinical record was			

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	reviewed on 9/11/13 at 10:15 A.M. Resident #32's diagnoses included but were not limited to, pneumonia, congestive heart failure, osteoarthritis, hypothyroidism, weakness and hypertension. Resident #32 was admitted to the facility on 4/19/13. Review of the "Physical Therapy Evaluation/Certification" dated 4/19/13, indicated Resident #32 ambulated 25 feet with a rolling walker with minimal assistance. Resident #32's short term goal was to ambulate with rolling walker seventy-five feet with minimal assistance. Resident #32's long term goal was to ambulate 125 feet to 150 feet. Review of the "Interdisciplinary Progress Note" dated 5/7/13, indicated Resident #32 was ambulating 60 feet with a rolling walker. A therapy noted dated 6/4/13, indicated Resident #2 was getting up unassisted and ambulating 50 to 60 feet using a rolling walker. A therapy note dated 6/28/13, indicated to discontinue skilled OT/PT (occupational therapy and physical			

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	therapy) due to the resident had met maximal functional level. The note indicated a recommendation for restorative nursing. Review of the "Restorative Nursing Program Therapy Referral Form" dated 7/8/13, indicated Resident #32 transferred 75 feet with a rolling walker with a minimal assist of one. Review of the "Daily Documentation for Restorative/Rehabilitation Nursing" indicated restorative nursing was not provided on July 1, 2, 3, 4, 5, 24, 25, 26, 29, 30 and 31, 2013. Restorative nursing was not provided August 1, 3, 4, 5, 8, 9, 18 and 19, 2013. A physical therapy order dated 8/20/13, indicated Resident #32 was to be seen three times a week for four weeks. A Physical Therpay note dated 8/29/13, indicated Resident #32 was unable to transfer or ambulate. During a telephone interview on 9/13/13 at 9:30 A.M., PRP PTA#1 stated, "Resident #32 on therapy. She was doing quite well when we left. We were leery of her doing ADL's (Activities of Daily Living) on			

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	her own. She was starting to get pretty close to independent/supervision/stand by assist. She was very close to being discharged." During an interview on 9/13/13 at 11:19 A.M., RCNA#1 indicated she was supposed to start working with Resident #32 on July 8, 2013 but she was pulled to the floor a lot in July. She indicated Resident #32 would refuse at times because she was tired. RCNA #1 indicated Resident #32 "never walked" for her. RCNA #1 indicated "I don't know what she would do for therapy." During an interview on 9/16/13 at 1:40 P.M., Resident #32 was observed in her room in a wheelchair. Resident #32 indicated, "When I first came in here I was in therapy and they were teaching me how to walk with the wheelchair. Now they are teaching me how to walk again. My legs just got stiff when they stopped." During an interview on 9/16/13 at 2:00 P.M., CNA # indicated "I just help her get out of bed and transfer, I don't walk her. I don't know how far she walks I just get her up to the bathroom and bed. If she does get physical therapy it would be			

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	documented in her chart." 3. Resident #28 was observed in his room asleep in his wheelchair on 9/9/13 at 11:45 a.m. At 12:30 p.m., the resident was observed in the dining room in his wheelchair asleep. Resident #28 was observed in his room asleep in his wheelchair on 9/10/13 at 10:50 a.m. At 12:00 p.m., the resident was observed to be propelled into the dining room for lunch. Resident #28's record was reviewed on 9/13/13 at 9:45 a.m. Resident #28's diagnoses included, but were not limited to CVA (stroke), weakness and unsteady gait (walk). A therapy consent form from [name of therapy company) dated 6/22/13, indicated the resident were going to receive occupational and physical therapy services under Medicare Part A and Medicaid. The resident's daughter had signed the form. A nursing notes dated 6/24/13, 6/25/13, 6/26/13, 7/1/13 and 7/22/13 indicated the resident was able to propel self in his wheel chair. A Physical therapy assessment note			

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	dated "week of 6/25-28/2013", indicated subjectively, the resident indicated "I want to be able to walk better". Current mobility status indicated minimal assistance with a rolling walker and ambulated up to 60 ft (feet) with supervision. The note indicated rehab potential was good. The resident was a stand by assist of one with "rolling" in bed, and minimal assistance of one for lying to sit and sit to stand from bed and wheel chair transfers to bed and toilet. The Balance dynamic stand was fair. Plan was to continue treatment per plan of care as tolerated, three times a week for four weeks with therapeutic exercise to BLE (bilateral lower extremities), therapy approved activities, gait/transfer training, improve functional mobility. Review of the Restorative Nursing Program Therapy Referral form, indicated the problems were decrease in ambulation skills and decrease strength to bilateral lower extremities. resident was ambulating with his rolling walker up to 75 feet with minimal assistance of one person, transfers with minimal assistance of one person and strength was fair to all extremities. Occupational and Physical therapy had recommended range of motion			

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	exercises and ambulation with goals provided. Instructions indicated to exercise the bilateral upper and lower extremities at 20 repetitions for each setting, bike exercises for 10 minutes for bilateral upper and lower extremities, ambulate with rolling walker up to 100 feet with minimal assistance of one person, and sit to stand from wheel chair to improve transfers. The start date was 7/8/13 six days a week for 6 weeks. Review of the range of motion restorative notes for July 2013, indicated the resident was only seen on July 12th, 17th and 18th. A weekly progress note indicated there was "not enough restorative" . Review of the Daily Program Documentation for Restorative/Rehabilitation Nursing dated July 2013, indicated the resident was seen for mobility training and range of motion on July 12th, 17th, 18th, 22nd, 23rd, 26th, 27th and 28th. Review of the range of motion notes and ambulation program notes indicated the resident was not seen from August 1 to August 7 and August 28th. A weekly progress note indicated there was "not enough			

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	restorative". A physician order dated 8/15/13, indicated OT/PT evaluation and treat as needed. A Physical Therapy Plan of Care dated 8/15/13 indicated the resident was assessed to be moderately dependent for transfer from sit to stand, bed to wheelchair, toilet and floor. Standing dynamic balance was poor. Gait analysis indicated the resident was able to ambulate 70 feet with moderate assistance. Review of the "Occupational Therapy Plan of Care" dated 8/23/13, indicated the resident was assessed and short/long term goals were initiated. The Neuromuscular upper extremitity range of motion indicated the resident demonstrated increased difficulty with left upper extremity. The clinical observations indicated the resident presented with decreased strength, endurance, decreased independence and safety with self care performance and safety and moor mobility. The resident was unable to propel self in the wheel chair to 20 feet without fatigue. Staffing schedules for August and September 2013 were reviewed on			

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	9/3/13 at 3:00 p.m. and indicated the following: a. On 8/1/13 (Thursday), the facility was staffed with two CNAs', restorative aide and a bath aide on the day shift. The schedule indicated a need for a CNA. b. On 8/2/13 (Friday), the facility was staffed with two nurses, three CNAs' and a shower aide on the day shift. There was not a restorative aide scheduled. The schedule indicated a need for a CNA. c. On 8/3/13 (Saturday), the facility was staffed with two nurses, two CNAs' and a restorative aide on the day shift. The facility had a CNA from an agency on the schedule. There was not a wound nurse on the schedule. d. On 8/4/13 (Sunday), the facility was staffed with two nurses and three CNAs' on the day shift. There was not a wound nurse, restorative aide or a shower aide on the schedule. e. On 8/5/13 to 8/7/13 (Monday to Wednesday), the facility had four CNAs' on the schedule for the day shift. There was not a restorative aide or a shower aide on the			

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	schedule. f. On 8/6/13 (Thursday), the facility had three CNAs' on the schedule on the day shift. There was not a restorative aide or a shower aide on the schedule. g. On 8/7/13 (Friday), the facility had four CNAs' on the schedule. There was not a restorative aide or a shower aide on the schedule. h. On 8/10/13 (Saturday), the facility had two CNA's on the schedule and a restorative aide on day the shift. The schedule indicated one nurse and two CNAs' on the night shift. The schedule indicated a need for a CNA on both shifts. i. On 8/11/13 (Sunday), the facility had two nurses and three CNAs' on the day shift. There was not a wound nurse restorative aide or a bath aide on the schedule. The schedule indicated a need for a CNA. j. On 8/17/13 (Thursday), the facility had three CNAs' and a restorative aide on the day shift. There was not a bath aide on the schedule. k. On 8/18/13 (Saturday), the facility had two nurses and three CNAs' on			

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	the day shift. There was not a wound nurse, restorative aide or a bath aide on the schedule. l. On 8/19/13 (Monday), the facility had three CNAs', restorative aide and a bath aide on the day shift. The schedule also indicated there was a need for a CNA. m. On 8/22/13 (Thursday), the facility had three CNAs' and a bath aide on the day shift. The schedule indicated the restorative aide was on vacation. There was not a CNA assigned to do restorative therapy. n. On 8/24/13 (Saturday), the facility had two nurses and three CNAs on the day shift. The restorative aide was scheduled until 11:00 a.m. There was one nurse and two CNAs on the night shift. The schedule indicated a need for two CNAs' on day shift and one CNA for night shift. o. On 8/25/13 (Sunday), the facility had two nurses and three CNAs' scheduled for day shift. There was not a restorative aide or a bath aide on the schedule. There was one nurse and two CNAs' on the night shift. The schedule indicated a need for a CNA on the night shift.			

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	p. On 8/31/13 (Saturday), the facility had two nurses and three CNAs' on the day shift. There was not a restorative aide or a bath aide on the schedule. The schedule indicated a need for a CNA. q. 9/1/13, 9/7/13 to 9/8/13 and 9/14/13 to 9/15/13 (Saturday and Sunday), the facility was staffed with two nurses three CNAs' on the day shift. There was not a restorative aide or a bath aide on the schedule. r. On 9/2/13 and 9/3/13 (Monday and Tuesday), there was no restorative aide to cover Restorative Aide #1 during her vacation. s. On 9/5/13 (Thursday), there was not a restorative aide or a shower aide on the schedule. The schedule indicated "do your own showers". t. On 9/7/13 (Saturday), the schedule indicated a need for a CNA on the night shift. u. On 9/9/13 (Monday), the facility had three CNAs' on the schedule. The Schedule indicated a need for a CNA on the day shift. v. On 9/15/13 (Sunday), there was not a restorative aide and a shower			

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	aide on the schedule. Restorative Aide #1 was interviewed on 9/13/13 at 11:20 a.m. Restorative Aide #1 indicated she had to be pulled away from her duties as a restorative aide and be put on the floor many times due to short staffing of CNAs. During an interview on 9/13/13 at 11:20 a.m., RCNA #1 indicated she had to be pulled away from her duties as a restorative aide and be put on the floor many times due to short staffing of CNAs'. During an interview on 9/13/13 at 12:00 p.m., the DoN indicated the RCNA #1 had to be pulled off of her assignment as a restorative aide due to staff quitting without notice. The DoN also indicated she has had a difficult time finding staff with experience and skills needed for the residents. During an interview on 9/18/13 at 2:10 p.m., the DoN indicated RCNA #1 was the only restorative aide. The DoN indicated they had put a plan into place to provide services to residents who required therapy while the facility made arrangements for another company to start. The facility			

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	did not have enough staff to meet the residents needs. RCNA #1 was frequently removed from her responsibilities of a RCNA. This Federal Tag relates to complaint number IN00133532. 3.1-17(a) 3.1-17(c)(4)			

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F000406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.			
	Based on observation, record review, and interview, the facility failed to ensure residents who required physical therapy, occupational therapy, and speech therapy, were provided these services. This deficient practice affected 1 of 5 residents reviewed for specialized rehabilitatvie services (Residents #41). Findings include: 1. Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Resident #41 had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, anemia, a history of a stoke with left sided weakness, a recent urinary tract infection (UTI), and seizures. A five day significant	F000406	F406 Were other residents identified with potential to be affected by the deficiency? All residents that have orders for therapy or who are identified to be on restorative programs are currently receiving those programs appropriately. The facility has a current Therapy provider that is providing services to all residents with therapy orders What measures and systemic changes were put in place to assure deficient practice does not recur? The facility has a new Therapy provider and all therapy services are being provided in accordance with the physician's order. The Administrator is responsible for assuring that a therapy contract remains in place and that the therapy services ordered by the physician are in place. When a new order for therapy is received, nurses are responsible for notifying therapy. Nurses have	10/16/2013

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	change Minimum Data Set Assessment Tool (MDS) dated 4/19/13, indicated Resident #41 was re-admitted to the facility on 4/12/2013, after being discharged from an acute care hospital, where he received treatment for an UTI. This MDS indicated Resident #41 was cognitively intact with a BIMS (brief interview mental score cognition assessment tool) score of 14:15, totally dependent on the assistance of one staff for locomotion, dressing, personal hygiene, bathing, transfers, toileting, and had received physical therapy and occupational therapy. During an observation on 9/10/2013 at 2:29 P.M., Resident #41 was observed sitting in his wheel chair in his room. Resident #41 had a therapeutic glove on his left hand/arm and leaned to the left in the wheel chair. During an interview on 9/10/2013 at 2:29 P.M., Resident #41 stated, "I was walking. Therapy is gone. They had someone in here. Had me lift my leg 20 times. I was walking in July now I can't.... They packed up on a Friday. They moved all the therapy stuff out. Nobody knows what happened to it-where it went. I came here for therapy. I was making good progress. They still charge me for rehabilitation and I ain't		been in-serviced related to communicating with therapy any new orders. The IDT reviews all orders each business morning. If a therapy order is identified, they will be the second review to assure that therapy is aware of the order and services are being initiated. Were any in-services/education provided to address deficient practice? Nurses were in-serviced related to assuring that proper communication occurs with therapy when orders are received for service Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly audit 5 residents who are identified to have orders for therapy services. The tool reviews presence of therapy in accordance with the physician's orders is followed appropriately. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Director of Nursing, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current facility policy was	

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	getting nothing. If I am going to be an invalid bed patient I am going to get the (curse word). I am not that far out. With help I can walk again but I need it every day. They won ' t tell me anything. I will go someplace else. I don't have a choice.. Either leave and get therapy or turn into a vegetable and they are taking my money. They get money from Medicare and Medicaid and my money. They are not giving me the service. You ask them about therapy and they say tomorrow or next week. Next week or tomorrow never comes." An un-timed physician's order dated 6/10/2013, indicated, "Late entry for 6/3/2013, extend skilled PT (physical therapy) 5/wk (week) X 6 wk for therapy exs (exercises) ble (bilateral extremities), therapy activity... gait transfer training modalities as indicated to improve functional mobility." A physical therapy weekly summary note dated 6/24/2013-6/28/2013, indicated Resident #41 was able to ambulate, with minimum to moderate assist, thirty feet with two repetitions per session, required minimum assistance to sit up from a flat position and to stand from a sitting position, and was independent with		utilized for training. No newly developed policy was needed. F 406 Provide/Obtain Specialized Rehab Services It is the policy of this facility to obtain and provide specialized rehab services for each resident. I. Corrective Action Taken Related to this Finding: Resident #41 has received new therapy orders. The new therapy company is here with the therapy agreement. Therapy services available with Physical therapy, occupational therapy and speech therapy. Restorative Aide has received training and updated job description for residents being discharged from therapy. II. Other Residents with the potential to be affected by this finding will be identified by: All residents in the facility that are identified as being affected by this finding have new therapy orders and have been seen by the therapist and programs initiated as indicated. . III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: All residents will have therapy orders addressed upon receipt. Therapy will be notified the same day the orders are received. Communication of these orders or any recommendation s will take place through the 24 hour sheet for nursing and discussed daily in the interdisciplinary team meeting. Therapy in-service completed 10/16/13 for communication and contact	

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	wheel chair mobility. This PT note indicated, "Pt (patient) is improving toward all goals of gait/transfers/balance and strength. Rehab (rehabilitation) potential is good. Cont (continue) tx (treatment) as tolerated to achieve long term goals...." A current care plan updated on 8/20/2013, indicated Resident #41 was at for falls due to a diagnosis of a stroke and left sided hemi-paresis. The goal listed was Resident #41 would not have falls or injuries from falls. Interventions listed to meet this goal included staff were to encourage him to attend and participate in therapy. During an interview on 9/12/2013 at 1:15 P.M., when asked what happened to the facility's therapy services, the Director of Nursing (DON) replied, "I don't know what happened. About two weeks ago they just pulled out of here." When asked how the facility was providing therapy services to the residents, she replied, "We have someone come in." During an interview on 9/12/2013 at 3:25 P.M., Resident #41 stated, "Therapy doctor came today. Said it may be tomorrow or Monday. He		personnel. Referral form reviewed IV. Corrective Actions will be monitored to Ensure Compliance by: The MDS Nurse along with the nurse designated for therapy liason will be responsible for assuring that these policies and procedures be carried out with each resident; The DON will monitor for compliance and report no less than monthly to the quality assurance committee. V. Completion Date: *10-16-13	

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	said if he got the word today he would start tomorrow. He is waiting on my doctor. First week in July they left not two weeks ago. They had me walking with a special walker to brace this arm. I could walk across the room up to three times. Now I have become a vegetable. I am getting weaker waiting on tomorrow." During an interview on 9/17/2013 at 12:15 P.M., the facility's current therapy provider's staff, PT (physical therapist) #4 indicated he had evaluated Resident #41 because he had not received an order to evaluate Resident #41. PT #4 stated, "We are here for only a couple of weeks. They need to communicate with us. I told him (Resident #41) we could not do anything until we have doctor's orders. The social worker went with me last Thursday 9/12/2013. He expressed his concerns about waiting to be on services...." When asked if he was aware Resident #41 had an order for a PT/OT evaluation dated 9/13/2013, he replied, "No, I didn't even know they got the doctor's order. May I please see it?" PT #4 indicated the facility was aware he was the contact person and they did not notify him the order for the evaluation had been obtained. PT #4 stated, "We are only here until the			

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	end of the month. We gave them a letter telling them that. After that I don't know what is going to happen.... One week is way too long to go without therapy-severe decline." During an interview on 9/18/2013 at 1:06 P.M., the DON indicated the order probably got missed. The DON indicated this happened with another resident and she would check to see if it was the same nurse. A physician's order dated 9/13/2013-9:15 A.M., indicated Resident #41 may have a physical therapy/occupational therapy evaluation During a telephone interview on 9/19/2013 at 4:15 P.M., PRP Physical Therapist #2 indicated Resident #41 was evaluated the day he was made aware of the order. His evaluation indicated Resident #41's current status was, "A max assist to ambulate 15 to 20 feet at the most with a platform walker and physical assistance. His transfer ability is moderate. His sit to stand ability is moderate. His static dynamic balance is poor with max assistance.. He is a high risk for falls and if he attempted to stand, walk, or reach for something without max assistance			

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	and a platform walker, he would fall." PRP Physical Therapist indicated his evaluation indicated Resident #41's status had declined since the last status recorded by the previous therapy company. 3.1-23(a)(1)			

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F000441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on interview and record review, the facility failed to establish	F000441	F441 Were other residents identified with potential to be	10/16/2013

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	and maintain an Infection Control Program which maintained records of corrective actions related to infections. This deficient practice had the potential to affect 38 of 38 residents who resided in the facility. Findings include: During an interview on 9/18/2013 at 11:17 A.M., the Director of Nursing (DON) indicated the infection control nurse kept records of residents' infections. During an interview on 9/18/2013 at 11:55 P.M., with the DON (Director of Nursing) present, the infection control nurse was queried regarding the facility's system for tracking and trending infections. The infection control nurse stated, "We have a monthly report that I submit to my DON and the Medical Director. It contains which hall has infection, infections in the entire building, and if the resident was in another room with a resident. " The infection control nurse was questioned regarding what happened with the information provided to the DON and the Medical Director. She replied, "Then they have a meeting and I am not included." The infection control nurse was questioned how the results of her		affected by the deficiency? All residents have been reviewed without any identified negative outcomes. Please see below for measures/systems that have been reinforced. What measures and systemic changes were put in place to assure deficient practice does not recur? The infection control nurse has been in-serviced related to facility policy on tracking infections. The infection control nurse is responsible for all tracking and trending of infections. As part of the IDT review, 24 hr reports and new orders are reviewed. If a new order is related to an infection, further review will occur to determine that type of infection. The IDT will be reviewing the tracking/trending of infections on a weekly basis. Any identified infection will be tracked and all appropriate interventions will be implemented to assist with prevention of repeat infections or the spreading of the infection. As a precaution, all staff members have been re-trained on proper infection control protocol. Were any in-services/education provided to address deficient practice? Infection Control nurse in-serviced on protocol for tracking/trending. All staff has been re-trained on proper infection protocol. Was a monitoring system implemented to ensure the deficient practice does not occur? A PI tool has been implemented to randomly	

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	reports were used to track possible sources of nosocomial infections and intervene with education. She replied, "I don't educate staff on this." When questioned on how she found out about which residents had infections She replied, "The nurses tell me at the end of the month." During an interview on 9/18/2013 at 12:30 P.M., the infection control nurse indicated culture results were not always available. The lab frequently had issues with their equipment. She indicated she did not call to get a verbal result when this happened. She indicated at times the results of the cultures arrived to late to be included in the information she provided to the DON for the meetings. The facility's documentation for infection control "tracking and trending" records for June, July, and August 2013, were reviewed. The June records indicated there were six nosocomial (infections acquired in the facility) which included urinary infections, eye infections, and shingles. Two of the residents shared a room. The July 2013 infection report was reviewed. This record indicted eight		audit 5 residents (if applicable) who have been identified to have infection. The tool will review proper trending and tracking and assure that interventions are in place to prevent spreading of infection. This tool will be completed weekly x3, monthly x3, and then quarterly x3. The Infection Control Nurse, or designee, will be responsible for assuring that the audits are completed appropriately. Any negative findings will be immediately corrected. This tool will be reviewed by the QA committee at normally scheduled meetings with additional recommendations as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? The current policies were utilized for training. F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the policy of the Alpha Home to MAINTAIN AN ESTABLISHED INFECTION CONTROL PROGRAM DESIGNED TO MAINTAIN A COMFORTABLE ENVIRONMENT AND PREVENT THE DEVELOPMENT AND TRANSMISSION OF DISEASE AND INFECTION.. Corrective Action Taken Related to this Finding: A long established infection control program is presented as in place. The documents of this program process are available to be	

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	of the nine infections were nosocomial infections. Four of those infections were urinary tract infections (UTI). Two of the UTIs were cultured and both indicated Eschericia coli was the bacteria that caused the infection. Three were respiratory infections and two were eye infections (conjunctivitis). The August 2013 infection control log indicated five of the six infections were nosocomial infections. Four of the infections were UTIs. Two of the four urine cultures indicated Eschericia coli was the bacteria which caused the UTI. During an interview at 12:15 P.M., the DON was asked what the facility's system was to track and trend the causes of infections and what was done with the results. The DON stated, "We have QA (quality assurance) meetings. If it is UTIs (urinary tract infections) the Medical Director will tell us what to monitor. No, I don't have documentation of this. I pass it on to my nurses. We don't have documentation but we would enforce hand washing." The DON indicated the facility did not have written policies and procedures which established method to monitor, investigate, document, and/or analyze		presented. II. Other Residents with Potential to be affected by this finding will be identified by: All residents are are at risk to be affected by this finding III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: The information collected by the infection control nurse will continue to be presented to the director of nurses monthly. The infection control nurse will be forward these reports to the medical director as part of the long established program. Any trends found in the quarterly QA meeting will be discussed and any recommendations followed. IV. Corrective Actions will be monitored to Ensure Compliance by: The Alpha Home corrective action plan to ensure compliance shall be accomplished by. Interdisciplinary Team will review the 24 hour report daily at the morning managers meeting. The interdisciplinary will review infection control each week. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. V. Corrected Action Completion Date *10-16-13	

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	the occurrences of nosocomial infections. 3.1-18(a) 3.1-18(1)(B) 3.1-18(b)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155717	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/16/2013
NAME OF PROVIDER OR SUPPLIER ALPHA HOME ASSOC OF GREATER INDIANAPOLIS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2640 COLD SPRING RD INDIANAPOLIS, IN 46222	

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F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to marred walls, dusty air/heat vents, torn wheelchair arms, stained grout, splatter on walls, missing hardware on cabinet doors and drawers and stained ceiling tile on 2 of 3 units throughout the facility, 1 of 1 dining room's. This had the potential to effect the 38 residents residing in the facility. (The 100 Hall, 300 Hall and Main dining room) Findings include: 1. Random observations on 9/9 and 9/10/13 as well as during the Environmental Tour on 9/17/13 at 10:00 a.m., with the Maintenance/Housekeeping/Laundry Supervisor, indicated the following: The 100 Hall: a. Room 101 A: The walls were marred, the bathroom floor along the wall had dust imbedded in the tile grooves. The was green/lime film in the bathroom sink for two days.	F000465	F465 Were other residents identified with potential to be affected by the deficiency? All resident rooms and common areas have been reviewed and corrections/repairs completed as indicated What measures and systemic changes were put in place to assure deficient practice does not recur? An in-service has been conducted for maintenance, nursing, and housekeeping staff related to cleanliness of resident rooms, bathroom, and common areas. Housekeeping is to clean each resident room, bathroom, and common area every day in accordance with the cleaning schedule. Maintenance is responsible for routinely checking proper functioning and repairs in all areas throughout the building as part of the preventive maintenance program. Nursing has the responsibility to notify housekeeping/maintenance if an issue is identified that needs resolution. Administration will be making rounds through the facility daily to assure that rooms/bathrooms/common areas are clean and in good repair. Were any in-services/education provided to address deficient practice? Maintenance, Housekeeping, and Nursing were	10/16/2013

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	There were brown splatter on the wall between the bed and the bathroom. The air unit had a thick layer of dust in the top and side vents. b. Room 103 A: The air unit had a thick layer of dust in the top and side vents. The corner wall was marred with a missing kickboard around the corner. The bathroom floor along the wall had dust imbedded in the tile grooves. A wheelchair in the bathroom had a torn arm rest. There were missing handles to the cabinet drawers which had resident's personal belongings in it. There were no paper towels or toilet paper in the bathroom. c. Room 104 A: The wall was marred behind the bed. The cabinet, which stored the resident's personal belongings, had missing handles on the door and drawers. The dresser was also marred. The air unit was rusted with rough edges. There was cob webs in the corner by the air unit and a cabinet with a mosquito in it (observed this for one week). d. Room 105 A: The air unit had a thick layer of dust in the top and side vents. There was green/lime film in the bathroom sink for two days. There was a missing handle on a		in-serviced related to the expectations of cleanliness and repairs. Was a monitoring system implemented to ensure the deficient practice does not occur? A performance improvement tool has been initiated that randomly observes 5 residents' rooms/bathrooms/common areas related to cleanliness, proper function and repair of building, equipment and furniture. The Administrator, or designee, will complete the tools weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected and additional training will occur. The Quality Assurance committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? Training occurred based on current facility policies. F 465 EFFECTIVE SAFE FUNCTIONAL SANITARY COMFORTABLE ENVIROMENT It is the policy of the Alpha Home to provide a safe functional sanitary and comfortable environment for residents, staff and the public. Corrective Action related to this finding: Room # 101 walls now have been sealed and prepped bathroom sink grouted, vents cleaned and dusted. Resident # 103 A, corner area prepped, baseboard	

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	cabinet drawer which contained the resident's personal belongings. e. Room 113 A: The air unit had a thick layer of dust in the top and side vents. There was a smeared brown substance on wall by the head of the bed. f. Water rings was observed on the ceiling around the sprinkler system in the 100 Hall and above the charts at the nurses station. The 300 Hall: a. Room 302 A/B: Orange splatter was observed next to bed B. The air unit had a thick layer of dust in the top and side vents. The walls were marred and the corner wall next to bed had chipped drywall and a missing piece of trim next to the floor. There was a thick layer of dust on the light fixtures on the bedroom wall and on the bathroom floor along the walll. The dust was observed imbedded in the tile grooves. Two residents resident in this room. b. Room 305 A: The air unit had a thick layer of dust in the top and side vents. There was dried plaster and marred walls. The curtain blinds was damaged. The air unit was dusty.		replaced, tile grooves cleaned, wheelchair removed, cabinet knob replaced paper towels and toilet paper into the bathroom. Room # 104 A, wall has been prepped, knobs placed of the furniture, air unit rust removed room deep cleaned. Room # 105A air unit dusted and cleaned, bathroom sink cleaned, cabinet drawer knob replaced. Room #113 air unit vents cleaned area around the head of the bead cleaned and prepped. There has been no negative outcome from the room repairs. Written policy review and staff acknowledgement signature forms signed on 10/16/13 This in-service trained the staff on best practices for reporting work orders and the completion of work assignment when assignments are completed, Corrective action plans implemented with employee violating noncompliance for non-communication to the administrator or his designee in his absent. The Alpha Home compliance of the resident room areas and common areas. The logs are review in the morning managers meeting to ensure compliance. This is the corrected action for those residents found to have been affected by the deficient practice. II. Other Residents with Potential to be affected by this finding will be identified by: All other residents had the potential to be affected by	

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	The bathroom floor along the wall had dust imbedded in the tile grooves. There was blue tape peeling along the wall paper boarder near the ceiling. c. Room 306 A/B: There was dried plaster on the wall. The bathroom floor along the wall had dust imbedded in the tile grooves. The air unit had a thick layer of dust in the top and side vents. Two residents reside in this room. d. Room 308 A/B: The air unit had a thick layer of dust in the top and side vents. The walls was oberved marred. The bathroom floor along the wall had dust imbedded in the tile grooves. The handle was broke on a cabinet door as well as missing handles on the drawers which contained resident personal belongings. Two residents reside in this room. e. Room 310 B: The walls was observed marred. The air unit had a thick layer of dust and in the top and side vents. The bathroom floor along the wall had dust imbedded in the tile grooves. The was chipped plaster around the air control unit on the wall. f. Room 312 A: The air unit had a		this finding; however, no other residents were affected. The work orders logs communication is shared on the nursing units with the meeting. The Alpha Home has implemented the appropriate corrective action with suspension and or termination of staff for a noncompliance. The reports are documented and reviewed with the managers meeting. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: The work order logs are documented daily and review at the managers meeting. The interdisciplinary team reviews the log sheets, incidents and accidents at each morning managers meeting. These best practices have been implemented to ensure the deficient practice does not recur. IV. Corrective Actions will be monitored to Ensure Compliance by: Administrator, Maintenance Director, and the interdisciplinary team will review all resident room work orders. All reports with audits with finding submitted to the Quality Assurance at its monthly meeting. This practice will be on going. The Quality Assurance Committee will review and make recommendation for continuous quality improvements, after three months the committee will determine if additional recommendation is necessary. V. Completion Date: 10/16/13	

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	thick layer of dust in the top and side vents. The Main Dining Room: a. Plastic covering over the chairs were torn. b. Splatter on the wall near the side exit doors. c. Thick layer of dust and insect debree along the window sills behind a vent/register. d. Stained water rings on the ceilings tiles above the charts at the station next to the Main Dining Room. Interview with the Maintenance/Housekeeping/Laundry Supervisor during the environmental tour on 9/17/13 at 10:15 a.m., indicated the rooms needed a "good deep cleaning" and the rooms were painted and repaired room by room when as they became empty. Indicated the sprinkler system sometimes leaks or there is condensation in the ceiling. The Supervisor indicated he would fix the handles on the cabinet doors and drawers. This Federal Tag relates to complaint			

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F000516 SS=F	483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. The facility must safeguard clinical record information against loss, destruction, or unauthorized use.			
	Based on observation and interview, the facility failed to ensure resident records were safeguarded from water damage from overhead sprinkler system, fire, and/or unauthorized use. This deficient practice had the potential to affect 38 of 38 residents who currently resided and and unknown number of residents who previously resided in the facility. Findings include: During a random observation on 9/10/2013 at 1:49 P.M., a note posted on a door in the 200 hall indicated, "This door to remain locked at all time." The door was unlocked. Observations of the room revealed several blue plastic tubs and paper boxes (some were covered and some were not) were stacked from floor to	F000516	F516 Were other residents identified with potential to be affected by the deficiency? All resident files are now stored in a manner that is in compliance with the regulation and safe guarded from damage. What measures and systemic changes were put in place to assure deficient practice does not recur? Medical Records has been in-serviced related to proper storage of medical records in accordance with the regulation. All records are currently stored in a manner that safe guards them from damage. In addition, a self-closing lock has been placed on the door where the medical records are stored so that the door locks automatically. Administration will be making daily rounds to assure that medical records door remains locked and files are stored appropriately. Were any in-services/education provided to	10/16/2013

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	the ceiling and in the middle of the room. Labels on the boxes indicated the containers stored residents' medical records, billing information, and employee files. This room was observed to have a sprinkler system installed. On 9/13/2013 at 12:41 P.M., with the maintenance supervisor present, the room was again observed unlocked. Inside the room observations of were made of thirty-six containers which contained resident financial records, discharged resident records dated 2008-2009, current resident records, that did not have lids or were in paper boxes. During an interview at this time, the maintenance supervisor stated, "This room should have never been unlocked." The maintenance supervisor indicated the sprinkler system worked and the records would have been destroyed if it was activated. He indicated he would make sure all records were stored properly and the door was locked. During an interview on 9/13/2013 at 1:44 P.M., the DON was asked to provide a policy regarding resident record storage. During an interview on 9/18/2013 at 1:49 P.M., with the Administrator and		address deficient practice? Medical Records has been in-serviced related to proper storage of medical records. Was a monitoring system implemented to ensure the deficient practice does not occur? A performance improvement tool has been initiated that at random times reviews the medical records storage to assure that files are stored appropriately and the door is locked if not under supervision. The Administrator, or designee, will complete the tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected and additional training will occur. The Quality Assurance committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of the tools. Were any policies developed or amended to address the deficient practice? A new policy has been implemented related to storage and safe guarding of medical records F 516 It is the policy of the Alpha Home to safeguard clinical record information against loss destruction or unauthorized use. Corrective Action Taken Related to this Finding: The records that were previously stored in boxes have been removed and placed in waterproof containers. The door has a self-closing lock in place. Maintenance and housekeeping	

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	the DON present, the DON indicated the records should have been covered, the door locked, and they did not have a policy regarding record storage. 3.1-50(d)		conducts daily checks to ensure the door is locked II. Other Residents with Potential to be affected by this finding will be identified by: All residents have the potential to be affected by this finding, however, no other residents where affected. III. Measures and Systemic Changes put into Place to Assure Removal of records and placed into waterproof container. Log sheet checking of the door self-locking lock. Deficit Practices do not recur are as Follows: Log sheet monitoring twice daily. Weekly checking on the interior room for safeguarded records. Validation that the lock is working. Highlighted sign to remind everyone the door must remain locked. IV. Corrective Actions will be monitored to Ensure Compliance by: The interdisciplinary team reviews the log sheet for the door locking and eye view of the records in storage. All reports and findings will be submitted to the quality assurance committee at its scheduled meeting. This monitoring audit record will be presented each month for the next three months with recommendation from the members from the quality assurance committee. 10/16/13	

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F000520 SS=H	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on observation, record review and interview, the facility failed to identify and implement plans of action to correct quality deficiencies related to restorative/specialized services to ensure safe eating and prevent decline in strength, transferring skills, locomotion skills, and range of motion. The facility failed to identify and implement corrective measures to prevent/prohibit and/or investigate allegations of resident abuse and	F000520	F520 Were other residents identified with potential to be affected by the deficiency? The Quality Assurance Committee has reviewed the 2567 and established protocol to assure that all residents' needs are addressed, services are provided per order and plan of care, care plans are being revised appropriately, Medicare cut letters are being provided appropriately, and any allegation of abuse is thoroughly investigated and the appropriate agencies notified.	10/16/2013

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	failed to ensure criminal background checks for 7 staff prior to beginning employment. The facility failed to identify and implement corrective action plans related to care plan revisions, infection control, and notification of Medicare Non-Coverage of services for 15 of 38 residents residing in the facility ((Residents #41, #32, #28, #34, #6, #A, #55, #35, #32, #47, #46, #2, and #48, Employees CNA #4, CNA #5, CNA #6, CNA #7, CNA #8, Dietary #1 and Housekeeping #1) Finidngs include: 1. Resident #41's record was reviewed on 9/12/2013 at 3:35 P.M. Resident #41 had diagnoses which included, but were not limited to, congestive heart failure (CHF), diabetes, anemia, a history of a stoke with left sided weakness, a recent urinary tract infection (UTI), and seizures. The record lacked documentation to indicate restorative services were provided to prevent decline in the resident ' s physical functioning (Refer to F311). The record lacked evidence to indicate Resident #41 was free from abuse (Refer to F223). The record lacked evidence that an allegation of abuser was thoroughly investigated (Refer to		The QA committee will continue to work towards quality improvement with plans of action to assure that all services offered are of the highest quality. What measures and systemic changes were put in place to assure deficient practice does not recur? The Quality Assurance Committee has reviewed the 2567 and the plan of correction associated with the findings. Action plans are in place related to the findings. Audit (PI) tools are also in place. The QA committee will begin reviewing the audit tools with additional recommendations or changes in the action plans if there it is identified that additional changes need to be made to reach higher quality. Please see F156, F157, F159, F223, F225, F226, F247, F248, F249, F279, F280, F309, F311, F312, F315, F325, F329, F332, F353, F406, F441, F465 and F516 Plans of corrections for specific interventions and specific audit tools. The QA committee has reviewed the regulations so that they are knowledgeable of their responsibilities as their training guide. The Administrator leads the committee and will work diligently to assure that all areas identified are corrected and remain in compliance. Were any in-services/education provided to address deficient practice? The QA committee has reviewed the regulations related to the responsibilities of the team.	

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	F225). 2. Resident #32's clinical record was reviewed on 9/11/13 at 10:15 A.M. Resident #32's diagnoses included but were not limited to, pneumonia, congestive heart failure, osteoarthritis, hypothyroidism, weakness and hypertension. The record lacked documentation to indicate therapy services were provided to prevent decline in the resident ' s ability to ambulate (Refer to F311). 3. Resident #28's record was reviewed on 9/13/13 at 9:45 a.m. Resident #28's diagnoses included, but were not limited to CVA (stroke), weakness and unsteady gait (walk). The resident's Admission MDS (Minimum Data Set) Assessment dated 7/1/13, indicated the resident was mildly cognitively impaired. The record lacked documentation to indicate therapy services were provided to prevent loss of ability to propel self in a wheel chair (Refer to F311). 4. Resident #34's record was reviewed on 9/16/13 at 10:30 a.m. Resident #34's diagnoses included, but were not limited to, depression,		Please see F156, F157, F159, F223, F225, F226, F247, F248, F249, F279, F280, F309, F311, F312, F315, F325, F329, F332, F353, F406, F441, F465 and F516 Plans of corrections for specific in-services Was a monitoring system implemented to ensure the deficient practice does not occur? Please see F156, F157, F159, F223, F225, F226, F247, F248, F249, F279, F280, F309, F311, F312, F315, F325, F329, F332, F353, F406, F441, F465 and F516 Plans of corrections for specific interventions and specific audit tools. The QA committee will be reviewing progress and audit tools with additional recommendations as needed to assure compliance. The Administrator overall is responsible for assuring that the areas identified are corrected and remain in compliance Were any policies developed or amended to address the deficient practice? Please see F156, F157, F159, F223, F225, F226, F247, F248, F249, F279, F280, F309, F311, F312, F315, F325, F329, F332, F353, F406, F441, F465 and F516 Plans of corrections for specific interventions and policy information. F 520 EFFECTIVE COMMITTEE – MEMBERS/MEET QUARTERLY/PLANS It is the policy of the Alpha Home to maintain a quality assessment and assurance committee which	

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	dementia, hypertension, and tachycardia (fast heart rate). The record lacked documentation to indicate a recommended speech therapy evaluation was completed to ensure safe eating (Refer to F325). The record lacked documentation to indicate an allegation of abuser was fully investigated (Refer to f225) 5. Employee records were reviewed on 9/17/2013. Documentation was lacking which indicated criminal history checks had been completed for the following employees: 1) CNA (certified nursing assistant) #4 -hire date 8/28/2013. 2) CNA #5-hire date 6/26/2013. 3) CNA #6-hire date 7/26/2013. 4) CNA #7-hire date 8/19/13. 5) CNA #8-no hire date available. 6) House Keeper #1-hire date 8/2/2013. 7) Dietary Staff #1-hire date 8/22/13. 6. Resident #6's record was reviewed on 9/13/13 at 10:50 a.m. Resident #6's diagnoses included but were not limited to, end stage dementia. Resident #6 was admitted to hospice on 3/26/13. The record lacked documentation to indicate coordination of care and specific interventions between the facility and hospice services (Refer to F279)		meets quarterly and identify issues with quality assurance and assessments. Develop and implement appropriate plans of action that will identify and implement appropriate plans of action to correct identified quality deficiencies. Corrective Action related to this finding: Staff members at the Alpha Home all have criminal background checks completed. Prior to employment the potential new hire shall all have their pre-employment file and checklist reviewed by human resource? New hire information and completed folders to be presented to quality assurance committee meeting. Corrective action plans completed on staff # 4, #5, # 6, #7 and employee # 8. This includes criminal background checks, employee checklists, and resident rights and abuse training. No staff begins orientation until signed checklist completed by manager reviewed by administrator and monitored by the quality assurance committee. Resident # 41 has been re- interviewed; the ISDPH has received a secondary follow up report with the staff person already being terminated. (Refer to F-225) Resident # 32 has therapy orders and is receiving therapy from qualified licensed therapist. Resident and or family member received notification on new therapy company. (Refer to F-311). Resident # 28 is receiving	

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	7. Resident #A's record was reviewed on 9/11/13 at 2:10 p.m. Resident #A's diagnoses included, but were not limited to, CVA (stroke) and dementia. A Comprehensive Admission MDS (Minimum Data Set) Assessment dated 2/12/13, indicated the resident was frequently incontinent of urine. The record lacked documentation to indicate a care plan had been developed to reduce/manage the resident ' s incontinence (Refer to F279). 8. During an interview at 12:15 P.M., the DON was asked what the facility's system was to track and trend the causes of infections and what was done with the results. The DON stated, "We have QA (quality assurance) meetings. If it is UTIs (urinary tract infections) the Medical Director will tell us what to monitor. No, I don't have documentation of this. I pass it on to my nurses. We don't have documentation but we would enforce hand washing." The DON indicated the facility did not have written policies and procedures which established method to monitor, investigate, document, and/or analyze the occurrences of nosocomial infections (Refer to F441). 9. Review of "Skilled Nursing facility		therapy and new therapy orders are in place. Resident and or family member notified of therapy. (Refer to F- 311) Resident # 34 therapy evaluated speech evaluation concluded. Conclusive report for resident abuse sent to ISDPH, care plan updated, additional narrative from staff completing fully investigated allegation of abuse. Staff person #1, #4, # 5, #6, #7, # 8, Corrective action plans completed. Copies of criminal background check submitted during survey. This includes criminal background checks, employee checklists, and resident rights and abuse training. No staff begins orientation until signed checklist completed by manager reviewed by administrator and with monitoring by the quality assurance committee. Resident # 6 has expired. Hospice however to integrate their team and care plan communication with the Alpha home team. Hospice team and Alpha Home team have meet with scheduled in service, new agreement implemented staff trained on coordination of facility care plan and integration of hospice overall plan of care. There is no resident # a listed in the resident sample. However if a resident is in need of a bowel and bladder assessment it is care plan and reviewed with the quality assurance completed. Completed resident care plan updated with instructions to manage urine	

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	Advanced Beneficiary Notice" letter dated 4/2/13, indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 4/19/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed by the resident who was severely cognitively impaired (Refer to F156). 10. Review of Resident #35 ' s "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 2/27/13 [sic], indicated Medicare coverage would end beginning 3/27/13. The MDS indicated the resident last day of physical and occupation therapy was 3/28/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." "...B. I do not want my bill services I continue to need for		incontinence. Facility implementation of bladder program with the Quality assurance meeting on 10/14/13(F - 279) The wound care nurse completes wound care reports weekly along with the monthly infection report. Policy and procedure implemented and training for staff to implement protocol. (F - 441) Infection control reports to be review by quality assurance committee and additional recommendations. The facility has implemented the new skilled nursing advanced beneficiary notice from the Medicare website. The letter sent out to families on 10/13/14 with notification of benefits and appeal rights. Other Residents with Potential to be affected by this finding will be identified by: All residents receiving therapy, notification of skilled nursing advanced beneficiary notice and the potential for abuse allegation had the potential to be affected by this finding; however, no other residents were affected. The communication is shared on the nursing units with the cuddle/ huddle meeting. . The Alpha Home has implemented the appropriate corrective action with suspension and or termination of staff for a noncompliance. The reports are documented and reviewed at the managers meeting and submission to the ISDPH for complete narrative and the conclusion of the	

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	submission to the intermediary for Medicare decision [sic]." The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed by the resident who was severely cognitively impaired (Refer to F156). 11. Review of Resident #32 ' s "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 3/28/13, did not indicate Resident #32's date of admission. The letter indicated Medicare coverage would end beginning 4/29/13. "...B. I do not want my bill services I continue to need for submission to the intermediary for Medicare decision [sic]." The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer (Refer to F156). 12. Review of Resident #47 ' s "Skilled Nursing facility Advanced Beneficiary Notice" letter dated		investigation. The Alpha Home is currently submitting all reports to the Department of Health. The Alpha Home will continue to report in a prompt manner, to the regulatory agency, resident's family, and physician. These follow up reports will continue with prompt submission to the ISDPH via fax, and written communication to ISDPH. III. Measures and Systemic Changes put into Place to Assure Deficit Practices do not recur are as Follows: Before hire checklist implement containing all information for a new hire implemented. Care planning with the hospice and Alpha home team implemented. Facility to submit pre and post investigation reports to ISDPH with narratives and conclusion to the reports. The interdisciplinary team reviews the new hire information daily, Medicare cut letters and therapy service submitted to families. IV. Corrective Actions will be monitored to Ensure Compliance by: Quality Assurance Recommendation team will review Pre employment hire lists, New and completed therapy orders, Medicare advanced skilled letters, Hospice intervention and care plans. All reports with audits with finding submitted to the Quality Assurance at its regular scheduled monthly meeting. This practice will be on going for the next three months. The Quality	

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	4/14/13, did not indicate Resident #47's date of admission. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 4/30/13. The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed with an "X" by the resident who was severely cognitively impaired Another "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 4/1513, did not indicate Resident #47's date of admission. The letter indicated "...indicated [Name of Resident #47] no longer qualifies as coverage under Medicare beginning 4/29/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." The letter indicated "...B. I do not want my bill services I continue to need for submission to the intermediary for Medicare		Assurance Committee will review and make recommendation for continuous quality improvements, after three months the committee will determine if additional recommendation is necessary. V. Completion Date: 10/16/13	

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	decision [sic]." The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed with the resident's name who was severely cognitively impaired. 13. Review of Resident #41 ' s "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 6/14/13, did not indicate Resident #41's date of admission. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 6/29/13. The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer (Refer to F156). 14. Review of Resident #46 ' s " Skilled Nursing facility Advanced Beneficiary Notice" letter dated			

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	5/27/13, did not indicate Resident #46's date of admission. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare beginning 6/4/13. The letter indicated there were efforts to contact the notifier "earlier in the day by person or telephone were unsuccessful." The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer. The letter was signed by the resident who was severely cognitively impaired (Refer to F156). , 15. Review of Resident #2 ' s "Skilled Nursing facility Advanced Beneficiary Notice" letter dated 8/12/13, did not indicate Resident #2's date of admission. The MDS (Minimum Data Set) Assessment indicated the resident was admitted into the facility on 8/26/12. The letter indicated "...reviewed your medical coverage and found services furnished [Name of Resident #55] no longer qualifies as coverage under Medicare			

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	beginning 3/13/13. The letter did not indicate if Medicare was to be billed for services. The letter did not indicate the name and address of the intermediary. The letter did not inform the beneficiary he/she would not have Medicare appeal rights if the bill was not submitted. There was not a signature of the Administrative Officer (Refer to F156). 16. Review of the Occupational and Physical therapy discharge note for Resident #48 indicated the resident was receiving Occupational and Physical therapy services until 6/28/13. A Medicare Non-Coverage form was not provided by the facility (Refer to F156). 17. A therapy consent form from [name of therapy company] dated 6/22/13, indicated Resident #28 was going to receive occupational and physical therapy services under Medicare Part A. A Medicare Non-Coverage form was not provided by the facility. This Federal Tag relates to complaint number IN00133532. 3.1-52(b)(2)			

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