

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155741	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/02/2013
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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203
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F000000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 22, 2013.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00126199, IN00126219, and IN00126028.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00124238 completed on 2/27/2013.</p> <p>Survey dates: March 26, 27, 28, and April 1 and 2, 2013</p> <p>Survey Team: Dinah Jones, RN - TC Marcy Smith, RN Leia Alley, RN Patti Allen, BSW</p> <p>Census bed type: SNF/NF: 47 Total: 47</p> <p>Census payor type: Medicare: 4 Medicaid: 37 Other: 6 Total: 47</p>	F000000	<p>This plan of correction is the center's credible allegation of compliance. Preparation and/or completion of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth in the statement of the deficiencies. The Plan of correction is prepared and/or executed solely because it is required by state and federal law.</p>	

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

TITLE

(X6) DATE

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

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	<p>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 12, 2013; by Kimberly Perigo, RN.</p>				

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F000253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to ensure the North Hall of the facility was free from odors. This had the potential to affect 14 of 74 residents residing in the facility. (Rooms N3, N4, N5, N6, N7, N8, N9, N10, and N11.)</p> <p>Findings include:</p> <p>During an observation on 3/28/13 at 9:33 a.m., of the North Hall, a strong, musky, foul odor was notable at the east end of the corridor near rooms N3, N10, N11, and the nurses station. The odor became stronger and was most notable at the west end of the corridor near room #7, located by the exit door. When standing directly in front of room #7, the odor was most notable.</p> <p>During observations on 4/1/13 at 2:00 p.m., and on 4/2/13 at 11:45 a.m. and at 2:23 p.m.; of the North Hall, a strong, musky, foul odor was notable at the east end of the corridor near the nurses station. The odor became stronger and was most notable at the west end of the corridor near room</p>	F000253	<p>Facility has deep cleaned resident room (#7N) on 4/16/2013. Facility also replaced resident (#7N) mattress on 4/17/2013 and will wash mattress daily to control. A check sheet was created on or before 4/26/2013 to monitor facility odors. Resident agreed on 4/16/2013 to allow facility care staff to assist in daily care and prn to insure odor is controlled. Facility staff will do daily checks starting on or before 4/26/2013 of resident areas for odors and odors will be dealt with immediately and accordingly. Smells of the facility will be addressed daily in morning stand up meeting and in facility Quality Assurance Meetings.</p>	04/26/2013			

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	<p>#7. When standing directly in front of room #7, the odor was most notable.</p> <p>During an interview on 4/2/13 at 4:30 p.m., the Executive Director, Director of Nursing, and Assistant Director of Nursing all indicated they were aware of the odor. The Director of Nursing and Assistant Director of Nursing both indicated they had approached the resident in room #7 and encouraged her to bathe per her shower schedule, but the resident had been resistant to bathing. The Assistant Director of Nursing indicated housekeeping had deep cleaned the room, but indicated the odor was still notable after the cleaning. The Director of Nursing indicated when the door of room #7 was opened, the odor permeated the corridor and was difficult to eliminate.</p> <p>3.1-19(f)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2013

FORM APPROVED

OMB NO. 0938-0391

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F000279 SS=D	<p>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.</p> <p>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.</p> <p>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).</p> <p>Based on observation, interview, and record review, the facility failed to develop a comprehensive plan of care for 1 of 3 residents in a sample of 3 residents who met the criteria for the development of comprehensive care plans. (Resident #E.)</p> <p>Findings Include:</p> <p>The clinical record for Resident #E was reviewed on 3/26/13 at 3:00 p.m.</p> <p>Diagnoses include but were not limited to, liver failure, cirrhosis</p>	F000279	Facility developed a care plan for liver failure for resident #E on 3/27/2013. A complete review of resident E's care plans was completed on 4/17/2013 for appropriateness and corrections were made. A full review of in-house resident care plans was started on 4/3/2013 and will be completed on 4/26/2013 for appropriateness and correction were made to all affected charts. A periodic review of resident care plans will done as needed in clinical meeting and quarterly in association with MDS. The head to toe care plan assessment was discontinued. Date of completion	04/30/2013

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	<p>(damage and scarring of the liver), and acites (fluid build up in the abdomen).</p> <p>The clinical record lacked a comprehensive care plan to manage and meet Resident #E's medical needs for liver disease and acites.</p> <p>During an interview with the facility Director of Nursing (DON) on 3/27/13 at 11:30 a.m., a request was made to review Resident #E's plan of care in regards to liver failure.</p> <p>During an interview with the DON on 3/27/13 at 2:30 p.m., she indicated the facility did not have a care plan and the facility would develop one that day.</p> <p>3.1-35(a)</p>		<p>4/26/2013</p> <p>Addendum: The facility has created a care plan audit tool which will be used to audit care plans upon admission, re-admission, significant change and quarterly to ensure that all significant issues for each resident are addressed in the care plan. The results of these audits will be reviewed at QA meeting monthly as a method to monitor the effectiveness of our care planning process.</p>		

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F000282 SS=G	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A) Based on observation, interview, and record review, the facility failed to provide services according to the resident's plan of care, to maintain personal hygiene and skin integrity. This affected 2 of 2 residents reviewed for residents requiring assistance with personal hygiene needs. (Residents #E and #66.)</p> <p>B) Based on observation, record review, and interview, the facility failed to ensure services were provided according to residents' plans of care, for passive range of motion exercises, splint application, and blood sugar monitoring, for 4 of 17 residents reviewed for services being provided according to their plans of care in a total sample of 17. (Residents #29, #35, #A, and #9)</p> <p>Findings include:</p> <p>A1)The clinical record for Resident #E was reviewed on 3/26/13 at 3:00 p.m.</p> <p>Diagnoses include but were not limited to, liver failure, cirrhosis</p>	F000282	<p>Resident E and #66 chart and activities of daily living documentation was reviewed. Staff was in-serviced on 3/29/2013 on ADL documentation. A check sheet was created for appointments and transfers, with the exception of emergencies, to insure residents are clean, dry, and in good order prior to leaving the facility. Facility has put in place a shower binder at each nurse's station, nursing staff were in-serviced on documentation and location of binders on 3/29/2013. New staff will be educated upon hire. On or before 4/26/2013 checks of activities of daily living documentation have been completed and will continue indefinitely. Facility Management will report during morning stand-up meeting and will do a full review of documentation during Quality Assurance Meetings. Resident #29, #35, A, and #9 charts and restorative program with documentation was reviewed. Staff was in-serviced of documentation and restorative program responsibilities. Management will check for completion were started on or before 4/26/2013 indefinitely. A</p>	04/30/2013	

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	<p>(damage and scarring of the liver), and acites (fluid build up in the abdomen).</p> <p>A Quarterly Minimum Data Set Assessment (MDS) dated 1/14/13 indicated Resident #E had a BIMS (Brief Interview for Mental Status) score of 15/15, indicating he was cognitively intact with no memory impairment. The MDS also indicated Resident #E required extensive assistance from staff for bed mobility, transfers, to take care of personal hygiene needs and is always incontinent of urine and bowel (has no control of bladder or bowel movements).</p> <p>A facility care plan dated 8/10/12 indicated, "Risk for skin break down due to incontinence of bowel and bladder" and a Goal that indicated, "No pressure ulcer formation" and "Resident will be clean, dry and odor free." Interventions to meet the goal indicated, "clean after each episode of incontinence" and "monitor skin for redness"</p> <p>A facility care plan dated 8/10/12 indicated, "Resident requires assistance from staff for activities of daily living due to morbid obesity." and a Goal that indicated, " Resident</p>		<p>review of restorative and restorative documentation by clinical staff will be done during clinical meeting and during Quality Assurance Meetings. A review of all facility residents on the restorative program was done and staff were in-serviced on restorative documentation and responsibilities. Checks are performed to insure responsibilities and documentation were properly completed for all residents on the restorative program. The facility management review of program will be addressed by clinical staff during morning clinical meeting and in the Quality Assurance Meetings. A complete record check of resident #9 and resident A was completed. DON discontinued the diabetic flow sheet Checks are performed on diabetic monitoring daily indefinitely. Clinical staff will review diabetic monitoring daily in clinical meeting. A review of all diabetic charting for all residents was reviewed, and Facility Management will check charting during morning clinical meeting.</p> <p>Addendum:</p> <p>Nurses have been instructed to update the plan of care, and CNAs have been instructed to refer to their CNA Assignment Sheets when providing care to the residents. Nursing staff will be in-serviced on 4/30/2013 to review these issues</p>		

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	<p>will be clean, dry and odor free." Interventions to meet the goal indicated, "Assist with bathing twice weekly", "Assist Resident with incontinent care and clean clothing as needed", and "Offer resident choices, such as white clothing to wear and time for resident's shower."</p> <p>A facility document titled "Pressure Ulcer Assessment, Braden Scale for Predicting Pressure Ulcer Risk" and dated 9/1/12 indicated Resident #E was not at high risk for pressure ulcers.</p> <p>During an interview on 4/1/13 at 10:30 a.m., via Electronic Mail (email), a staff person from a local area hospital, indicated some of the staff that worked with Resident #E were concerned for Resident #E's well being. The staff person indicated they were concerned with Resident #E's cleanliness, and current status of skin condition. The staff personal also indicated that when transport personnel picked up Resident #E from the facility on 3/15/13, they noted Resident #E was lying in a puddle of urine.</p> <p>During an observation of incontinence care on 4/1/13 at 3:25 p.m., and in presence of CNA #1 (Certified</p>		and to ensure that they provide care to residents as indicated by the residents' plan of care.				

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	<p>Nurses Assistant), Resident #E was noted to have a urine soaked bed sheet and a top sheet he was covered with, a urine soaked hospital type gown on his body, and two urine soaked hand towels that were covering his genitalia. CNA #1 stated, "I always find him like this" and indicated, "I had him a urinal in here and he was staying dry, but I don't know where the urinal has gone, I haven't been here for a few days."</p> <p>Resident #E was noted to have bright red areas of excoriation in his groin region, the right side of the groin area was very bright red and noted to be bleeding slightly when CNA #1 wiped facility barrier cream (thick cream to protect the skin) away from the area. Resident #E moaned in pain and had facial grimacing while CNA #1 provided this care. The front side, inner thigh area was noted to be slightly red and appeared to be chapped.</p> <p>Resident #E was turned over by CNA#1 and a large area of the bottom of the buttocks area and down the back of the thighs were noted to be bright red with scant amounts of barrier cream on the areas. When CNA #1 cleaned the anus of Resident #E, a medium amount of feces, from</p>						

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	<p>a previous bowel movement, was noted on the wash cloth. Resident #E yelled out and moaned in pain during the entire time of the cleaning of the groin, anus, and legs.</p> <p>Resident #E's mattress was noted to have a large wet, urine soaked spot on it, dead skin, and spotted with old, dried skin cream.</p> <p>During an interview with Resident #E on 4/1/13 at 4:00 p.m., Resident #E indicated they rarely get a bath or shower and stated, "Its such an ordeal to get cleaned up, let alone get an entire bath or shower," they also indicated they frequently ask to get out of bed, however staff do not accommodate the request.</p> <p>Shower records for Resident #E were requested on 4/1/13 at 4:15 p.m.</p> <p>Showers for Resident # E were as follows...</p> <p>Showers on February 1 [facility indicates resident refused shower this date, but was offered], 12, 15, and March 19 [bed bath given], 22 [bed bath given], and 26 [bed bath given], indicating Resident #E had 2 showers and 3 bed baths over the course of 59 days.</p>			

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	<p>"Licensed Nurse Weekly Skin Assessment" sheets were reviewed on 4/1/13 at 4:20 p.m.</p> <p>Skin Assessments were done and indicated as follows...</p> <p>Skin Assessment 2/26/13 indicated "buttocks excoriated (raw/red skin)"</p> <p>Skin Assessment 3/5/13 indicated "groin excoriated"</p> <p>Skin Assessment 3/19/13 indicated "red area under Right armpit"</p> <p>Skin Assessment 3/26/13 indicated there was bruising and swelling of the abdomen and lower limbs</p> <p>Skin Assessment 3/28/13 indicated "rectum has hemorrhoids that are swollen and lower extremities slightly swollen"</p> <p>Further information was requested from the facility Administrator on 4/1/13 at 4:30 p.m., in regards to showering for Resident #E.</p> <p>During an interview with the Administrator on 4/1/13 at 4:45 p.m., she indicated no further information was available.</p> <p>A2) During an observation and following interview with Resident #66 on 4/2/13 at 10:30 a.m., she indicated she was upset while waiting for</p>						

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	<p>assistance to get into the shower. Resident #66 stated, "You get a shower maybe once every 2 weeks, let alone 2 showers each week!"</p> <p>The clinical record for Resident #66 was reviewed on 4/2/14 at 10:45 a.m.</p> <p>Diagnoses include but were not limited to, hemiplegia (where one side of the body is paralyzed).</p> <p>A facility care plan dated 2/13/13, indicated "Resident requires assistance from staff for activities of daily living due to hemiplegia related to CVA", goals to the care plan indicated "Resident will be clean, dry, odor free and appropriately dressed", interventions to the goal indicated "Assist with bathing twice weekly, and personal hygiene daily as needed" and "offer resident choices, such as what clothing to wear and time for resident's shower."</p> <p>A review of Resident #66's shower records on 4/2/13 at 11:00 a.m., indicated Resident #66 was offered a shower on 3/8/13 but refused to take it due to being in too much pain, then would have had a shower on 3/12/13 but was at the hospital, then had a shower on 3/15/13, the next shower was on 3/22/13, then on 3/26/13, then</p>						

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	<p>on 4/2/13. During the month of March, 2013, Resident #66 was offered 5 showers instead of 8, and went seven days between showers from 3/15/13 to 3/22/13 and went seven days between showers from 3/26/13 to 4/2/13.</p> <p>Further information was requested from the facility ADON (Assistant Director of Nursing) on 4/2/13 at 11:45 a.m., in regards to showers being done for Resident #66. No further information was available.</p> <p>B1) The record of Resident #29 was reviewed on 4/1/13 at 10:55 a.m.</p> <p>Diagnoses for Resident #29 included, but were not limited to, stroke with right side paralysis, muscle spasms, and chronic pain.</p> <p>A Quarterly Minimum Data Set (MDS) assessments dated 12/12/12 and 3/11/13, indicated Resident #29 was independent with her decision making.</p> <p>A Monthly Summary, dated 3/5/13, indicated Resident #29 had contractures (an abnormal shortening of muscles) in her right arm.</p> <p>An Occupational Therapy Evaluation,</p>				

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	<p>dated 1/4/13, indicated, "Discharge to restorative for daily passive range of motion (moving of a joint through its range of motion without exertion by the resident) & splinting."</p> <p>During an observation on 4/1/31 at 11:00 a.m., Resident #29's right hand was observed to be tightly fisted. She was not wearing a hand splint.</p> <p>Recapitulated physician's orders dated March 1 - 31, 2013, original dates not available, indicated Resident #29 was to have a right hand splint applied at bedtime and to wear the splint 5-6 hours, as tolerated.</p> <p>A care plan for Resident #29, dated 1/19/13, updated through 4/19/13, indicated a problem of, "Resident is unable to independently move Right arm due to hemiplegia [paralysis] related to CVA [stroke]." The goal was, "Resident will tolerate two sets of 15 repetitions of Passive Range of Motion [PROM] to Right arm (shoulder, elbow and wrist) daily through next review." Interventions included, "Perform two sets of 15 repetitions of Passive Range of Motion to Right arm (shoulder, elbow and wrist) daily, six to seven days per week."</p>			

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	<p>A "Restorative Program" for Resident #29, dated 1/19/13, indicated, "...Problem: 1) Resident requires assist with Right PROM...Specific Instructions: 1) Resident will receive PROM 2 set x 15 reps [repetitions] of right Upper extremity to all joints to maintain ability to splint and assist with ADL [Activities of Daily Living] performance..."</p> <p>A Treatment Record for March, 2013, indicated Resident #29 did not have the hand splint applied on March 2, 6, 28, and 30.</p> <p>A Rehabilitation/Restorative Service Delivery Record for March, 2013, for Resident #29, indicated, "Perform Passive Range of Motion to all joints of Right arm (shoulder, elbow, wrist) two sets of 10 repetitions to improve ADL independence. This Service Delivery record indicated the resident did not receive PROM to all joints of her right arm on March 9, 10, 16, 17, 18, 23, 24, 27, 30, and 31.</p> <p>During an interview with Resident #29 on 4/1/31 at 11:00 a.m., she indicated "They rarely put my splint on or do my hand exercises. Maybe once a month. I can't remember the last time."</p>						

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	<p>B2) The record of Resident #35 was reviewed on 4/1/13 at 1:10 p.m.</p> <p>Diagnoses for Resident #35 included, but were not limited to, stroke with paralysis, dementia with agitation, and behavior disturbances.</p> <p>A quarterly Minimum Data Set Assessment, (MDS) dated 1/28/13, indicated Resident #35 was severely impaired in his decision making.</p> <p>A care plan for Resident #35, dated 1/24/13 and current through 5/1/13, indicated a problem of, "Resident is unable to independently move legs and arms due to muscle contractures. (abnormal shortening of muscles)" The goal was, "Resident will tolerate three sets of 20 repetitions of Passive Range of Motion (moving of a joint through its range of motion without exertion by the resident) to bilateral legs." Interventions included, "Perform Passive Range of Motion on bilateral legs and arms doing three sets of 20 repetitions..."</p> <p>A care plan for Resident #35, dated 1/24/13 and current through 4/24/13, indicated a problem of, "Resident is unable to put left hand splint on and off. Splint is needed to address</p>			

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	<p>contracture in left hand." The goal was, "Resident will tolerate left hand splint two times per day for two hours each with assistance from staff six to seven days per week through next review." Interventions included, "Assist to don left hand splint twice daily..."</p> <p>Resident #35 was not wearing a splint on his left hand during on observation on 4/1/13 at 1:10 p.m.</p> <p>A Rehabilitation/Restorative Service Delivery Record for Resident #35, for March 2013, indicated, "Perform Passive Range of Motion to bilateral arms and legs, three sets of 20 reps, including all joints six to seven days per week. The record indicated PROM was not provided for the resident on March, 9, 10, 16, 17, 18, 23, 24, 27, 30, and 31, 2013.</p> <p>The same delivery record indicated, "Assist resident to don Left hand splint, on for two hours at a time, twice per day, six to seven days per week." The record indicated the left hand splint was not applied on March 9, 10, 16, 17, 18, 23, 24, 27, 30, and 31, 2013.</p> <p>During an interview with the Assistant Director of Nursing on 2/26/13 at 3:15</p>				

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	<p>p.m., she indicated she was not able to find any further information regarding passive range of motion services not provided or splint applications for Residents #29 and #35. She indicated the facility now has a Certified Nursing Assistant (CNA) who is assigned Monday through Friday to provide all the restorative services. She indicated all of the CNA's have been trained to provide these services if the Restorative Aide is not available.</p> <p>B3-a) Clinical Records for Resident #9 were reviewed on 4/1/13 at 1:45 p.m.</p> <p>Diagnoses included but were not limited to m/s (multiple sclerosis, a disease that affects the brain and spinal cords), anxiety disorder, depression, and seizure disorder.</p> <p>Quarterly Minimum Data Set (MDS) assessment dated 3/11/13, indicated Resident # 9 was independent with her decision making, total dependence-two person physical assist for Activities of Daily Living (ADL) assistance, Restorative Nursing Programs: Range of motion (passive), Splint or brace assistance.</p> <p>A facility Plan of Care dated 12/17/12 indicated Resident # 9 is, "Unable to</p>			

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	<p>independently move bilateral (both) legs due to paraplegia related to MS (Multiple Sclerosis)." "Resident will tolerate three sets of 20 repetitions of Passive Range of Motion to bilateral legs." "Perform Passive Range (where staff assists the resident move their joints) of Motion on hips, knees, and ankles doing 3 sets of 20 repetitions."</p> <p>A facility Rehabilitation /Restorative Service Delivery Record dated for March 2013, indicated Resident # 9 was on the facility's "Restorative" program. The form indicated, "Perform Passive Range of Motion to bilateral legs (hips, knees, and ankles) doing 3 sets of 20 repetitions to each joint, six to seven days per week." The form indicated resident was not offered Range of Motion Services (ROM) on March 10, 16, 17, 18, 23, and 24, 2013.</p> <p>During an interview with the facility Assistant Director of Nursing (ADN) on 4/1/13 at 2:45 p.m., she indicated the days on the facility Rehabilitation /Restorative Service Delivery Record that were blank indicated the service was not done.</p> <p>B3-b) The Clinical Record for Resident #9 was reviewed on 4/1/13</p>			

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	<p>at 10:00 a.m.</p> <p>Diagnoses included but were not limited to, diabetes mellitus (a condition affecting blood sugar levels).</p> <p>Resident #9's clinical record indicated a physicians order started 11/1/12 to "Check blood sugar daily, call MD [medical doctor] if below 70 or above 405."</p> <p>The clinical record indicated blood sugar levels were not checked on the following dates... March 3, 8, 10, 11, 12, 18, and 21, 2013.</p> <p>Further information was requested from the ADON (Assistant Director of Nursing) on 4/1/13 at 11:30 a.m.</p> <p>During an interview with the ADON on 4/1/13 at 3:00 p.m., she indicated no further information was available and was unsure of why the blood sugar levels had not been checked on the dates mentioned.</p> <p>B4) The Clinical Records for Resident #A were reviewed on 4/1/13 at 9:00 a.m.</p> <p>Diagnoses included but were not</p>				

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	<p>limited to, diabetes mellitus (a condition affecting blood sugar levels).</p> <p>Resident #10's clinical record indicated a physicians order started 3/28/11 to "Check blood sugar two times daily, call MD [medical doctor] if below 70 or above 400."</p> <p>The clinical record indicated blood sugar levels were not checked on the following dates... March 13, 14, 15, 17, 19, 20, 23, and 24, 2013 for the scheduled 6:00 a.m. check and on 3/21/13 for the scheduled 4:00 p.m. check.</p> <p>3.1-35(g)(2)</p>			

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F000318 SS=E	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure splint application assistance and passive range of motion exercises were provided to prevent a decrease in range of motion for 3 of 3 residents reviewed having range of motion services provided in a total sample of 17. (Residents #29, #35, #9)</p> <p>Findings include:</p> <p>1. The record of Resident #29 was reviewed on 4/1/13 at 10:55 a.m.</p> <p>Diagnoses for Resident #29 included, but were not limited to, stroke with right side paralysis, muscle spasms, and chronic pain.</p> <p>Quarterly Minimum Data Set (MDS) assessments dated 12/12/12 and 3/11/13, indicated Resident #29 was independent with her decision making.</p>	F000318	<p>Resident #29, #35, and #9 charts and restorative program with documentation was reviewed. Staff was in-serviced of documentation and restorative program responsibilities. A review of documentation was started on or before 4/26/2013 will continue indefinitely. A review of restorative and restorative documentation by clinical staff will be done during clinical meeting and during Quality Assurance Meetings. A review of all facility residents on the restorative program was done and staff were in-serviced on restorative documentation and responsibilities. Checks are performed to insure responsibilities and documentation were properly completed for all residents on the restorative program. The review of program will be addressed by clinical staff during morning clinical meeting and in the Quality Assurance Meetings.</p> <p>Addendum: All residents will be reviewed upon admission, re-admission, quarterly, and upon change of condition to determine if the resident could</p>	04/30/2013	

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	<p>A Monthly Summary, dated 3/5/13, indicated Resident #29 had contractures in her right arm.</p> <p>An Occupational Therapy Evaluation, dated 1/4/13, indicated, "Discharge to restorative for daily passive range of motion (moving a joint through its range of motion without exertion by the resident) & splinting."</p> <p>During an observation on 4/1/31 at 11:00 a.m., Resident #29's right hand was observed to be tightly fistled.</p> <p>Recapitulated physician's orders dated March 1 - 31, 2013, original dates not available, indicated Resident #29 was to have a right hand splint applied at bedtime and to wear the splint 5-6 hours, as tolerated.</p> <p>A care plan for Resident #29, dated 1/19/13, updated through 4/19/13, indicated a problem of, "Resident is unable to independently move Right arm due to hemiplegia [paralysis] related to CVA [stroke]." The goal was, "Resident will tolerate two sets of 15 repetitions of Passive Range of Motion [PROM] to Right arm (shoulder, elbow and wrist) daily through next review." Interventions included, "Perform two sets of 15</p>		<p>benefit from therapy or restorative nursing services.</p> <p>All CNAs have been instructed that they are responsible for providing restorative services to residents to whom they are assigned. This eliminates the problem of restorative nursing not being provided when the restorative aide is absent or pulled to a CNA assignment. The restorative documentation is located in the CNA's ADL book for convenience of documenting restorative nursing program minutes provided.</p>	

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	<p>repetitions of Passive Range of Motion to Right arm (shoulder, elbow and wrist) daily, six to seven days per week."</p> <p>A "Restorative Program" for Resident #29, dated 1/19/13, indicated, "...Problem: 1) Resident requires assist with Right PROM...Specific Instructions: 1) Resident will receive PROM 2 set x 15 reps [repetitions] of right Upper extremity to all joints to maintain ability to splint and assist with ADL [Activities of Daily Living] performance..."</p> <p>A Treatment Record for March, 2013, indicated Resident #29 did not have the hand splint applied on March 2, 6, 28, and 30.</p> <p>A Rehabilitation/Restorative Service Delivery Record for March, 2013, for Resident #29, indicated, "Perform Passive Range of Motion to all joints of Right arm (shoulder, elbow, wrist) two sets of 10 repetitions to improve ADL independence. This Service Delivery record indicated the resident did not receive PROM to all joints of her right arm on March 9, 10, 16, 17, 18, 23, 24, 27, 30, and 31.</p> <p>During an interview with Resident #29 on 4/1/31 at 11:00 a.m., she indicated</p>						

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	<p>"They rarely put my splint on or do my hand exercises. Maybe once a month. I can't remember the last time."</p> <p>2. The record of Resident #35 was reviewed on 4/1/13 at 1:10 p.m.</p> <p>Diagnoses for Resident #35 included, but were not limited to, stroke with paralysis, dementia with agitation, and behavior disturbances.</p> <p>A quarterly Minimum Data Set Assessment, dated 1/28/13, indicated Resident #35 was severely impaired in his decision making.</p> <p>A care plan for Resident #35, dated 1/24/13 and current through 5/1/13, indicated a problem of, "Resident is unable to independently move legs and arms due to muscle contractures." The goal was, "Resident will tolerate three sets of 20 repetitions of Passive Range of Motion to bilateral legs." Interventions included, "Perform Passive Range of Motion [moving a joint through its range of motion without exertion by the resident] on bilateral legs and arms doing three sets of 20 repetitions..."</p> <p>A care plan for Resident #35, dated</p>			

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	<p>1/24/13 and current through 4/24/13, indicated a problem of, "Resident is unable to put left hand splint on and off. Splint is needed to address contracture in left hand." The goal was, "Resident will tolerate left hand splint two times per day for two hours each with assistance from staff six to seven days per week through next review." Interventions included, "Assist to don left hand splint twice daily..."</p> <p>Resident #35 did not have a splint on his left hand during an observation on 4/1/13 at 1:10 p.m.</p> <p>A Rehabilitation/Restorative Service Delivery Record for Resident #35, for March 2013, indicated, "Perform Passive Range of Motion to bilateral arms and legs, three sets of 20 reps, including all joints six to seven days per week. The record indicated PROM was not provided for the resident on March, 9, 10, 16, 17, 18, 23, 24, 27, 30, and 31, 2013.</p> <p>The same delivery record indicated, "Assist resident to don Left hand splint, on for two hours at a time, twice per day, six to seven days per week." The record indicated the left hand splint was not applied on March 9, 10, 16, 17, 18, 23, 24, 27, 30, and</p>						

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	<p>31, 2013.</p> <p>During an interview with the Assistant Director of Nursing on 2/26/13 at 3:15 p.m., she indicated the facility now has a Certified Nursing Assistant (CNA) who is assigned Monday through Friday to provide all the restorative services. She indicated all of the CNA's have been trained to provide these services if the Restorative Aide is not available.</p> <p>3) Clinical Records for Resident #9 were reviewed on 4/1/13 at 1:45 p.m.</p> <p>Diagnoses included but were not limited to m/s (multiple sclerosis, a disease that affects the brain and spinal cords), anxiety disorder, depression, and seizure disorder.</p> <p>Quarterly Minimum Data Set (MDS) assessment dated 3/11/13, indicated Resident # 9 was independent with her decision making, total dependence-two person physical assist for Activities of Daily Living (ADL) assistance, Restorative Nursing Programs: Range of motion (passive), Splint or brace assistance.</p> <p>A facility Plan of Care dated 12/17/12 indicated Resident #9 is, "Unable to independently move bilateral (both)</p>				

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NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 2630 S KEYSTONE AVE INDIANAPOLIS, IN 46203			
(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			
	<p>legs due to paraplegia related to MS (Multiple Sclerosis)." "Resident will tolerate three sets of 20 repetitions of Passive Range of Motion to bilateral legs." "Perform Passive Range (where staff assists the resident move their joints) of Motion on hips, knees, and ankles doing 3 sets of 20 repetitions."</p> <p>A facility Rehabilitation /Restorative Service Delivery Record dated for March 2013, indicated Resident # 9 was on the facility's "Restorative" program. The form indicated, "Perform Passive Range of Motion to bilateral legs (hips, knees, and ankles) doing 3 sets of 20 repetitions to each joint, six to seven days per week." The form indicated resident was not offered Range of Motion Services (ROM) on March 10, 16, 17, 18, 23, and 24, 2013.</p> <p>During an interview with the facility Assistant Director of Nursing (ADN) on 4/1/13 at 2:45 p.m., she indicated the days on the facility Rehabilitation /Restorative Service Delivery Record that were blank indicated the service was not done.</p> <p>3.1-42(a)(2)</p>						

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to implement their plan of action, to correct identified quality deficiencies of Comprehensive Care Plans, and Restorative Services/ Range of Motion (ROM) from Annual Survey completed on 1/24/13 as evidenced by deficient practice in care areas. This had potential of affecting 47 of 47 resident residing in the facility.</p>	F000520	The facility held a Quality Assurance meeting on 4/18/2013. The 4/18/2013 meeting members included DON, SS, HFA, Rehab, MDS, ADON and MD. Quality Assurance meetings will be held monthly, members will include DON, SS, HFA, MDS, Rehab, ADON and other facility management on an as needed bases. Monthly Quality Assurance meetings will be held indefinitely and every quarter the Medical Director will attend a	04/26/2013

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	<p>Finding include:</p> <p>1a) The clinical record review of Resident # 29 on 4/1/13 at 10:55 a.m., indicated that Resident # 29 was not receiving Restorative Services/ROM as care planned.</p> <p>b) The clinical record review of Resident # 35 on 4/1/13 at 1:10 p.m., indicated that Resident # 35 was not receiving Restorative Services/ROM as care planned.</p> <p>c)The clinical record review of Resident # 9 on 4/1/13 at 1:45 p.m., indicated that Resident # 29 was not receiving Restorative Services/ROM as care planned.</p> <p>2) The clinical record for Resident # E was reviewed on 3/26/13 at 3: p.m.. Diagnosis include but were not limited to, liver failure, cirrhosis (damage and scarring of liver), and acites (fluid build up in the abdomen).</p> <p>The clinical record lacked evidence of a care plan for Resident # E having a liver failure or management of the medical condition.</p> <p>During an interview with the DON on 3/27/13 at 2: 30 p.m., she indicated the facility did not have such care</p>		Quality Assurance meeting. The facility has hired a Quality Assurance Nurse.	

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	<p>plan and the facility would develop one that day.</p> <p>During an interview on 4/2/13 at 4:00 p.m., the ADON indicated the area of Restorative/ROM and Comprehensive Care Plans had been identified and brought before the QA & A committee. The committee had developed and implemented a plan of action (The Care Plan Committee has created a head to toe assessment form which will be used at each care plan review for each individual resident. This will be used as a tool for the team to assess all areas of needs, including ostomy and restorative needs. The Care Plan Committee will report to the QA Committee regarding the effectiveness of the head to toe assessment form to identify areas in need of care planning) with completion date of 2/23/13. The plan is not effective as evidenced by deficient practice in care areas of Restorative/ROM and Comprehensive Care Plans.</p> <p>3.1-52(b)(2)</p>						