STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155304		05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF NEW CASTLE, THE	1000 N 16TH ST NEW CASTLE, IN 47362

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 4, 5, 6, 9, 10, and 11, 2016 Facility number: 000201 Provider number: 155304 AIM number: 100267910 Census bed type: SNF: 2 SNF/NF: 44 Total: 46 Census payor type: Medicare: 10 Medicaid: 28 Other: 8 Total: 46 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 30576 on May 13, 2016	F 0000	The creation and submission of this plan of correction does not constitutean admission by this provider of any conclusion set forth in the statement ofdeficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction beconsidered the letter of credible evidence and request a desk review in lei ofpost re-certification on or after 6.10.16.	

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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F 0272 SS=D Bldg. 00	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. Based on interview and record review the facility failed to accurately note a Minimum Data Set (MDS) assessment	F 0272	The creation and submission of this plan of correction does not constitutean admission by this provider of any conclusion set forth	06/10/2016

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	for a resident with no natural teeth (edentulous) for 1 of 1 residents reviewed for MDS accuracy (Resident #73). Finding include: Interview with Resident #73 on 5/5/16 at 1:50 p.m., indicated he did not have dentures and would like to have some. The resident was observed not to have any teeth or dentures. Review of the record of Resident #73 on 5/6/16 at 11:10 a.m., indicated the resident's diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, major depression, adult failure to thrive, alcohol dependence induced psychotic disorder, generalized anxiety, hypertension, hypothyroidism and alcohol abuse with alcohol induced mood disorder. The Admission MDS assessment for Resident #73, dated 12/24/15, indicated the resident was not marked for "no natural teeth or tooth fragments (edentulous), the resident had to ability to make himself understood and understood others.		in the statement ofdeficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction beconsidered the letter of credible evidence and request a desk review in lei ofpost re-certification on or after 6.10.16. **F-272** It is the policy of thefacility to ensure that MDS assessments are accurate including addressing andassessing residents with no natural teeth. The MDS for Resident #73 has been corrected.His desire for dentures has been referred to his physician and to the SSD toaddress and to obtain a dental referral pursuant to obtaining dentures. His care plan has been reviewed and updated. All residents who have nonatural teeth have the potential to be affected by this finding. A facility wide audit hasbeen completed to ensure that all MDSs for the residents who reside in the facility are correct as far as reflectingthe accurate assessment results for teeth/dentures. Any necessary correctionswere made. Any residents who do not havenatural teeth have been interviewed and orally assessed for the possibility ofobtaining dentures if that is indicated for their well-being and to improvetheir quality of life. These targetedresidents have been referred to their respective physicians and to the SSD toaddress and to obtain a dental referral pursuant to obtaining	

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	Interview with Resident #73 on 5/6/16 at 12:52 p.m., indicated he had not had any teeth since he has been at the facility. Interview with MDS coordinator on 5/10/16 at 2:15 p.m., indicated the Admission MDS assessment for Resident #73 was marked incorrect, it should have been marked edentulous (no natural teeth). The MDS coordinator indicated the facility would not have implemented a careplan for a resident with no natural teeth, unless there was an issue. The MDS coordinator indicated she would correct the Admission MDS assessment for Resident #73. 3.1-31(c)(9)		dentures. The DON/Designee will review completed MDSsweekly to ensure that the dental portion has been completed accurately based onan oral assessment having been completed and documented. This monitoring will continue until 4consecutive weeks of zero negative findings is achieved. After that 5 completed MDSs will be reviewedweekly by the DON/Designee for a period of not less than 6 months to ensureongoing compliance. After that, randommonitoring will occur. Note: Anyconcerns will be addressed as found. Care plans will be reviewed and updated asindicated for these residents. At an in-service held forthe MDS Coordinator on 5.27.16 the importance of completing the MDS accurately,timely and completely with emphasis on the dental section being completed basedon the findings of an oral assessment being completed was reviewed. Any failure to follow the points of the in-service will result infurther education and/or progressive discipline as indicated. At the monthly QA meetingsthe results of the MDS monitoring will be reviewed. Any patterns will be identified, however, anyconcerns will have been addressed/corrected as found.	
F 0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE			

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Bldg. 00	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 have an interim care plan to address a resident's needs for end of life care, who was admitted for comfort care (Resident #63), and failed to to have a care plan for a resident receiving an antidepressant (Resident # 30). This affected 2 of 15 residents reviewed for care planning. Findings include: 1. Resident #63's record was reviewed on 5/10/2016, at 1:43 p.m. Admission diagnoses, dated 2/19/16, indicated	F 0279	**F-279** It is the policy of thefacility to ensure that residents have care plans, including interim care plansin place for residents who reside in the facility. Resident #63 expired as stated in thesurvey. Resident #30 has a care plan toaddress the use of an antidepressant drug. Residents who reside inthe facility have the potential to be affected by this finding. A facility wideaudit was	06/10/2016

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	non-traumatic intracerebral hemorrhage and dementia without behavioral disturbance. Physician's admission orders, dated 2/19/16, included, but were not limited to, oxygen at 2 liters a minute using a nasal cannula, do not resuscitate, and NPO (nothing by mouth). A "History and Physical" from a local hospital, with a hospital admission date of 2/16/16, indicated: "Chief complaint: confused and drowsy. History of Present Illness: Patient is a pleasant 89-year-old female with a history of depression, dementia, and hypothyroidism. The family called the Emergency Medical Service as the patient was having confusion. This started this morning and [Resident #63] was more drowsy. The patient has been sick with a cough and was started on a Z-pack (antibiotic) this morning. ED (emergency department) evaluation showed that she had a massive head bleed. The family is aware of the very poor prognosis, and they wanted to pursue comfort care. Throughout interviewing the patient, the patient did have an episode of becoming awake and responded to some of my questions...Overall, the patient has a very poor prognosis She does appear comfortable...past medical history:		conducted to ensure that all appropriate concerns/issues are careplanned with measureable goals and interventions in place. This includes interim care plans for newlyadmitted residents or residents who are admitted for comfort care as well asany resident on an antidepressant medication. Any necessary additions to resident care planswere completed. The IDT team will review10 care plans weekly making any necessary additions or deletions asindicated. This monitoring will continueuntil 4 consecutive weeks of zero negative findings is achieved. Afterwards, 3 care plans will be reviewed weeklyfor a period of not less than 6 months to ensure ongoing compliance. After that, random monitoring will occur. At an in-service held for nursesand the IDT team on 6.6.16 and 6.8.16, the care plan process including interimcare planning and the importance of accuracy and	

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	Significant for depression, hypothyroidism, osteoarthritis, and dementia...Disposition: Expected length of stay is greater than 2 midnights. It is possible the patient may expire here in the hospital. If not, we will pursue hospice, then may need to be discharged to an ECF (extended care facility) for comfort care." During an interview, on 5/09/2016 at 3:54 p.m., the Director of Nurses (DoN) indicated Resident #63 was admitted with a brain bleed, she was palliative care only, and had lived 4 days after admission. No care plan was in the clinical record to address the needs of a resident receiving end of life care. 2. Resident #30's record was reviewed on 5/06/2016 at 11:25 a.m. Current diagnoses included, but were not limited to: mild intellectual disabilities, repeated falls, generalized muscle weakness, arthritis, Courgette's disorder, epilepsy, peripheral vascular disease, depression, anxiety, insomnia, history of venous thrombosis and embolism, obsessive-compulsive disorder, psychotic disorder schizophrenia spectrum, high blood fats, constipation, and gastro		timeliness and completeness ofcare plans was reviewed and discussed. Any staff who fail to comply with the points of the in-service will befurther educated and/or progressively disciplined as indicated. At the monthly QA meetings,the results of the care plan monitoring will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be writtenby the committee. Any Action Plan will bemonitored weekly by the Administrator until resolution.	

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	esophageal reflux disorder. A quarterly Minimum Data Set (MDS) assessment, dated 2/29/16, indicated Resident #30 was moderately impaired in cognitive skills for daily decision making, had no moods or behaviors, and received antipsychotic medication, antidepressants, and anticoagulants. Progress notes, dated 3/15/16 at 2:38 p.m., indicated: "N.O. (new order) noted. Reduce Prozac (antidepressant) to 10 mg (milligrams) PO (by mouth) Q am (every morning)...." The Prozac had been changed to 10 mg po qd (every day) for depression on 3/15/16. Progress notes dated 4/20/16 at 4:15 p.m. indicated "[Physician's name] made recommendation to increase Prozac to 20 mg d/t (due to) failed GDR (gradual dose reduction). [Resident's physician] notified with new order noted. Sister notified of new order." During an interview, on 5/10/16 at 4:22 p.m., the Minimum Data Set (MDS) assessment Coordinator indicated the Prozac is included in the care plan for obsessive compulsive disorder. A care plan, dated 9/21/15, indicated a			

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	focus of: "Res (resident) has a dx (diagnosis) of ocd (obsessive compulsive disorder). Goal: res will have no more than 2 episodes of ocd related behaviors tnr (through next review). Interventions: app[roach] in calm manner, enc[ourage]to voice feelings, meds as directed, notify md (physician) prn (as needed), offer support, psych[iatric] eval[uation] prn." The care plan did not address the use of the antidepressant. A policy and procedure for "Care Plans" was provided by the Administrator on 5/11/16 at 11:22 a.m. The policy indicated, but was not limited to, "Guidelines: It is the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. Responsibility: All members of the interdisciplinary team. Coordinated by the MDS Coordinator...Procedure: This is completed in the PCC (Point Click Care) care plan section and/or hard section of the record. 1. Each resident upon admission or a significant change of condition will be assessed by all disciplines (i.e., MDS and other departmental assessment tools). 3. The initial care plan will be completed as			

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	soon as possible after admission. 4. The interdisciplinary team along with the resident and/or family members will identify resident problems, needs and strengths. 5. For each problem, need or strength a resident-centered goal is developed...6. Staff approaches are to be developed for each problem/strength need...7. All goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition...." 3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)			
F 0280 SS=D Bldg. 00	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			

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	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 interview and record review the facility failed to update and revise a resident's care plan to accurately reflect the resident's current diet order and code status for 1 of 15 residents reviewed for careplan's (Resident #45). Finding include: Review of the record of Resident #45 on 5/9/16 at 11:05 a.m., indicated the resident's diagnoses included, but were not limited to, repeated falls, senile degeneration of the brain, difficulty walking, muscle weakness, dysphasia (difficulty swallowing), hypertension, major depression and hypothyroidism. The physician order for Resident #45, dated 3/28/15, indicated to discontinue the mechanical soft diet and initiate a puree diet (blended food for a smooth texture), carbonated beverage with each meal every 2-3 bites to facilitate swallow initiation.	F 0280	**F-280** It is the policy of thefacility to ensure that care plans are updated and revised to reflect thecurrent diet orders for the residents as well as their current codestatus. Resident #45 has their currentdiet order as well as their current code status reflected in their care plan. Residents who reside inthe facility have the potential to be affected by this finding. As stated in the response for F-279, afacility wide audit was conducted to see that all care plans are current andaccurate as written. Going forward, atthe daily CQI meetings, the review of the 24 Hour Report, new or changed ordersand IDT discussion will prompt the	06/10/2016

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	Careplan dated 3/15/16 (revision date) indicated the resident meal intakes are variable and the resident has experienced a significant wt loss down 10.4 % since February 2016. The interventions included, but were not limited to, will receive a regular diet with chopped meat per the physician order. The physician order for Resident #45 dated 4/19/16, indicated the resident was ordered to be a Do Not Resuscitate (DNR). The careplan for Resident #45, dated 2/18/16, indicated the resident was a full code status. Interview with the Director Of Nursing (DON) on 5/9/16 at 1:11 p.m., indicated Speech Therapy made changes to the diet orders and the nurse taking off the physician order for the diet change should have updated Resident #45's care plan to reflect the new diet order. The DON indicated nursing or Social Services should have updated Resident #45's careplan for the current code status of DNR. Interview with Resident #43's family member on 5/9/16 at 1:30 p.m., indicated the resident was on a diet with chopped		appropriate Department Head to address andupdate the care plan appropriately. Thisprocess will be ongoing. Further, themonitoring of care plans, education on care plans and QA meeting follow up onthe care plan monitoring as stated in the response to F-279 will ensure thatthe care plans are updated and revised for accuracy, including diet orders andcode status as required by F-280.	

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	meat, but he was unable to eat it. The family member indicated he would chew and chew, but now that he was on a puree diet he was eating much better. The family member indicated they had talked with the physician about the resident's code status and it was decided the resident should be a DNR. The Care plan policy provided by the Administrator on 5/11/16 at 11:22 a.m., indicated it was the intent of the facility that each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care. The procedure included, but were not limited to, "all goals and approaches are to be reviewed and revised as appropriate by a team of qualified persons after each assessment and upon significant change of condition. 3.1-35(c)(2)(B)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			

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	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, interview and record review, the facility failed to thoroughly assess and document a resident's skin condition for 1 of 3 residents reviewed for non-pressure related skin conditions of 5 who met the criteria for non-pressure related skin conditions, and failed to accurately assess a resident's oral status for a resident who was admitted with no dentures and desired to have dentures for 1 of 3 residents reviewed for dental status and services of 3 who met the criteria for dental status and services. (Resident #65 and #73) Findings include: 1. Resident #65's record was reviewed on 5/9/16 at 1:10 p.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, convulsions, mononeuropathy, muscle weakness, difficulty walking, and a history of falls. Resident #65's quarterly Minimum Data Set (MDS) assessment dated 4/5/16,	F 0309	**F-309** It is the policy of thefacility to ensure that residents have any skin condition well assessed anddocumented. This includes pressure areasas well as non-pressure areas. Additionally, that interventions are careplanned to address any concerns. Further,it is the facility's policy to ensure that residents have an accurate oralstatus assessment completed upon admission and then as per policy and/orregulation or as indicated. Additionally, that interventions are careplanned to address any concerns. Resident #65 has had a head to toe skin assessment. Any areas identified were documented. There are treatments and care plans in placefor any skin issues of resident #65. Resident #73 is on the list	06/10/2016

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	indicated she understood and had the ability to understand others. She was cognitively intact in her daily decision making skills. She required limited assistance of 1 person to walk dress, and toilet. She had no skin tears. An "Incident Report" for Resident #65 dated 5/1/16 at 6:44 a.m., indicated she was found on her knees beside her bed. Resident #65 had stated she fell getting into her bed. She had a scratch on her right arm that measured 5.5 centimeters (cm). She was assisted back to bed. A "Progress Note" for Resident #65 dated 5/1/16 at 8:43 a.m., indicated she was found on her knees beside her bed. She had a scratch on her right arm that measured 5.5 cm. A "Weekly Skin Assessment" for Resident #65 dated 5/3/16 at 3:15 p.m., indicated she had a new skin tear on her chest from her fingernails. The skin tear measured 1.5 cm by 0.5 cm. The skin assessment had not addressed the scratch on her right arm or discoloration on her right elbow. A "Weekly Skin Assessment" for Resident #65 dated 5/10/16 at 3:37 p.m., indicated she had a skin tear on her chest. The skin assessment had not addressed		to see the dentist pursuant to obtainingdentures. Residents who reside inthe facility have the potential to be affected by this finding. There has been a facility wide skin sweep atwhich time all residents who had any skin issue/condition was addressed. This includes assessment, notification tofamily and physician, obtaining a treatment, care planning anddocumentation. The DON/Designee willmonitor weekly skin sheets each week going forward to see that they arecompleted. Additionally, theDON/Designee will complete skin assessments on 10 residents weekly to verifyfindings on the weekly skin assessments completed by nursing. These verification skin assessments willcontinue until 4 consecutive weeks of zero negative findings is achieved. After that, 2 verification skin assessmentswill be done weekly for a period of not less	

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	the scratch on her right arm or the discoloration on her right elbow. On 5/4/16 at 11:49 a.m., Resident #65 was observed with a scratch on her right arm. She indicated she had received the scratch after she had fell and hit the trash can in her bedroom. On 5/6/16 at 11:02 a.m., Resident #65 was observed with a dark scabbed area on her right arm near her elbow approximately 2 inches long and purplish discoloration covering her entire elbow. She indicated she had received the wounds after she fell and hit the trash can in her bedroom. She denied any other skin wounds. On 5/9/16 at 9:50 a.m., Resident #65 was continued to be observed with the dark scabbed area on her right arm near her elbow approximately 2 inches long and purplish discoloration covering her entire elbow. On 5/10/16 at 10:31 a.m., the MDS Coordinator indicated no skin assessment had been documented on the scratched area of Resident #65's right arm after her fall on 5/1/16. The MDS Coordinator indicated the wound had been documented on the Incident Report. No treatment had been ordered for the		than 6 months to ensure ongoingcompliance. After that, random auditswill occur. Note: Any concerns will be addressed and corrected as found. The assessment and monitoring of dentalconcerns has been addressed in F-272. At an n-service held fornurses on 6.6.16 and 6.8.16, the following was reviewed: 1.SkinAssessments—When ? Whom? Why?—What to do if findings? 2.PressureAreas-Assessme nt/Notification/Treatment/C are Planning/Follow up 3.Non-PressureAreas-Asse ssment/Notification/Treatm ent/Care Planning/Follow up 4.SWAT-Skin WeightAssessment Team—What is it? What does the “team” do? 5.OralAssessments-When? Whom? Why? What to do if findings? 6.Questions/Answers	

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	scratched area. No plan of care had been initiated for non-pressure related skin areas. On 5/11/16 at 11:18 a.m., Resident #65 was observed with most of the dark scabbed areas missing from her right arm wound near her elbow. The wound bed was pinkish/reddish in color and the skin surrounding the wound was pinkish/reddish in color. She indicated she had scratched the scabs off because the wound itched. Her right elbow was light purplish in color. She provided an observation of a circular wound on her chest approximately the size of a dime with a pinkish/reddish wound bed and pinkish/reddish skin surrounding the wound. No further assessment documentation was available in Resident #65's record related to her right arm wounds after 5/1/16. A "Skin condition Monitoring" procedure provided by the MDS Coordinator on 5/11/16 at 3:00 p.m., indicated the following: "Guideline: Residents with skin lesions/wounds will be monitored and documented. Responsibility: Charge Nurse, Director of Nursing or designee. Procedure: 1) When the Charge Nurse is aware of skin lesions, wounds, venous		Any staff who fail tocomply with the points of the in-service will be further educated and/orprogressively disciplined as indicated. At the monthly QAmeetings, the results of the verification skin assessments will be reviewed,however any concerns will have been corrected as discovered. Any patterns will be identified. Ifnecessary, an Action Plan will be written by the committee. Any Action Plan will be monitored by theAdministrator until resolution.	

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	ulcers, or other skin abnormalities, the area is to be assessed and documented...3) Initiate treatment per Physician's Order which is to include: a) type of treatment b) how often to be done c) how to be cleansed, if appropriate d) site of application...4) Documentation of skin conditions must occur upon identification and at least once each week. Assessment must include: a) characteristics (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue) b) treatment and response to treatment c) prevention techniques" 2.) Interview with Resident #73 on 5/5/16 at 1:50 p.m., indicated he did not have dentures and would like to have some. The resident was observed not to have any teeth or dentures. Review of the record of Resident #73 on 5/6/16 at 11:10 a.m., indicated the resident's diagnoses included, but were not limited to, alcohol dependence with alcohol induced persisting dementia, major depression, adult failure to thrive, alcohol dependence induced psychotic disorder, generalized anxiety, hypertension, hypothyroidism and alcohol abuse with alcohol induced mood disorder.			

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	Resident #73's record indicated he was admitted to the facility on 12/17/15. The Admission assessment for Resident #73, dated 12/18/15 at 12:06 a.m., indicated the resident had dentures and wore them. The nursing summary for Resident #73, dated 12/18/15 at 12:21 a.m., indicated the resident had "dentures/partial plate (fit well)". The nutritional risk assessment for Resident #73, dated 12/22/15 at 3:20 p.m., indicated "chewing/swallowing problems" were "dentures but refuses to wear them)". The nursing summary for Resident #73, dated 3/26/16 at 12:12 a.m., indicated the resident had "dentures/partial plate (fits well)". The nutritional risk assessment for Resident #73, dated 4/22/16 at 11:22 a.m., indicated the resident did not wear dentures. The physician order for Resident #73 with a start date of 12/19/15, indicated the resident was ordered a "no restriction diet".			

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	The Admission Minimum Data Set (MDS) assessment for Resident #73, dated 12/24/15, indicated the resident was not marked for "no natural teeth or tooth fragments (edentulous), the resident had to ability to make himself understood and understood others. Interview with Resident #73 on 5/6/16 at 12:52 p.m., indicated he had not any teeth since he was admitted to the facility. The resident indicated he did have "false teeth" before coming to the facility, but had lost them. The resident indicated he had been without "false teeth" about six or seven months. The resident indicated he had not seen a dentist since he was admitted to the facility. The resident did not have dentures in at this time and indicated his lunch was good. The inventory sheet for Resident #73 dated, 12/18/15 and 1/28/16 , dentures were not marked as a personal effect the resident had brought into the facility. The consent to see the dentist was signed by Resident #73, but did not indicate the date it was signed. During observation on 5/9/16 at 12:20 p.m., Resident #73 was eating in his room a regular diet. The resident did not			

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	have any dentures in place. Interview with Resident #73 on 5/10/16 at 10:35 a.m., indicated he had lost his dentures before coming to the facility and would like to have dentures. The resident was observed without dentures in place. During observation and interview with the Social Service Director (S.S.D.).on 5/10/16 at 1:30 p.m., the S.S.D. searched the room of Resident #73 for dentures with the resident's permission and was unable to find any dentures, denture cup or any denture adhesive. The resident reported to the S.S.D. that he had lost his dentures at home before coming into the facility. The S.S.D. called the resident's Power Of Attorney (POA) at this to verify the resident had lost his dentures before coming to the facility on 12/17/15. The POA indicated Resident #73 had lost his dentures prior to coming to the facility. The S.S.D. indicated she was unsure why Resident #73's assessments were marked the resident had dentures and agreed dentures were not marked on the resident's inventory sheet. The S.S.D. indicated the resident had not seen a dentist since he was admitted to the facility. The S.S.D. indicated when the resident was first admitted he signed the consent that he did not want to see the facility dentist. The S.S.D. indicated she			

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	was unsure when Resident #73 decided he wanted to see the dentist as the consent form was not dated. The S.S.D. indicated the resident was on the list to see the dentist on 5/27/16. Interview with the Director Of Nursing (DON) on 5/11/16 at 10:13 a.m., indicated the admitting nurse should visibly look at the resident's mouth and ask the resident if they have dentures during the admission assessment. The DON indicated the nurse should also visibly look at the resident's oral status when a nursing summary assessment was completed. The DON indicated the Register Dietician should visibly look at the resident's oral status and collect their own data when completing a nutritional risk assessment. 3.1-37(a)			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates			

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	that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
	Based on observation, interview and record review, the facility failed to implement a toileting program to help maintain and restore bladder function for 1 of 2 residents who met the criteria for urinary incontinence (Resident #26). Finding include: Review of the record of Resident #26 on 5/6/16 at 1:38 p.m., indicated the resident's diagnoses included, but were not limited, weakness, multiple fractures, repeated falls, asthma heart failure and chronic kidney disease. The Admission "Bladder/Bowel" assessment for Resident #26, dated 12/1/15 at 12:00 p.m., indicated the resident was not continent and did not know how long the resident had been incontinent. The resident was wet 1-2 times a day. The resident was wet during the day and night. It was unable to determine if the resident was continent of stool. The "Bowel and Bladder continence and incontinence screen and	F 0315	**F-315** It is the policy of thefacility to ensure that residents who would benefit from a toileting program areplaced on a toileting program to help maintain and/or restore bladder functionas much as possible. Resident #26 hasbeen placed on a toileting program. Residents who reside inthe facility and who are incontinent may have the potential to be affected bythis finding. A facility wide review wasconducted on incontinent residents to determine through assessment anddiscussion if they would be candidates for a toileting program to enhance the quality of theirlives. This targeted list of residentswas placed on a toileting	06/10/2016

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	recommendations" for Resident #26, dated 12/1/15 at 10:25 p.m., indicated the resident never voids appropriately without incontinence. The resident was never incontinent of stool. The resident required the assistance of two people to get to the bathroom. The resident was usually aware of the need to use the toilet. The recommendations were the resident was incontinent of bowel and/or bladder. "Proceed with the "Bowel and Bladder incontinence history review" for further evaluation to determine eligibility for a structured toileting program. The Admission Minimum Date (MDS) assessment for Resident #26, dated 12/3/16, indicated the resident was not on a toileting program. The resident was occasionally incontinent of his bladder and was always continent of his bowels. The resident required extensive assistance of one person to use the restroom. The Quarterly MDS assessment for Resident #26, dated 2/29/16, indicated the resident had the ability to understand others and make himself understood. The resident's daily decision making was reasonable and he was cognitively intact for daily decision mailing. The resident was not on a toileting program. The resident was frequently incontinent of		program. Thiswas shared with their family and physician. Toileting programs were care planned and placed on the CNA assignmentinformation. The DON/Designee will monitor all new admissions or readmissionsfor the potential of being placed on a toileting program, based on assessmentand voiding patterns. At the time of care planmeetings residents who are not completely continent will be considered for atoileting program. This will be anongoing process. If placed on atoileting program, this will be shared with the resident's family andphysician. Toileting programs will becare planned and placed on the CNA assignment information. At an in-service held fornursing staff 6.6.16 and 6.8.16, the following was reviewed: 1.Bowel/BladderAssessmen	

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	urine and always continent of bowels. The resident required extensive assistance of one person to use the restroom. The careplan for Resident #26 dated 12/4/15, at risk for skin breakdown due to decreased mobility. The interventions included, but were not limited to, provide toileting and peri care as needed and (5/9/16) "toilet every two hours" was added. Interview with Resident #26 on 5/9/16 at 10:51 a.m., indicated sometimes he knew when he had to use the restroom and sometimes he did not know. The resident indicated he needed help to the restroom and was unable to use the restroom by himself. The resident indicated he was not on a scheduled toileting program where staff took him to the bathroom before meals or when he got up in the morning. The resident indicated the staff check my "diaper" before every meal and change it. The resident was visibly wearing a brief under his pants. Interview with the Director Of Nursing (DON) on 5/9/16 at 2 p.m., indicated the assessment for Resident #26 on 12/1/16 for bowel and bladder was marked incorrectly for question #1 it should of		ts—When? Why? 2.ToiletingProgram-Who is a candidate? 3.Notifications andCare Planning 4.CNA AssignmentUpdate 5.Reconsider atCare Plan Meetings 6.Questions and Answers Any staff who fail tocomply with the points of the in-service will be further educated and/orprogressively disciplined as indicated. At the monthly QA meetingsthe results of the success of the toileting programs will be reviewed. Any patterns will be identified. If necessary, an Action Plan will be writtenby the committee. Any Action Plan willbe monitored by the Administrator until resolution.	

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	been always voids appropriately without incontinence. He goes to the restroom occasionally during the night he would be incontinent. Interview with the DON on 5/10/16 at 2:36 p.m., when Resident #26 was admitted there were two assessments completed for his bowel and bladder function and each assessment was completed by two different nurses and when they asked the resident the questions, the resident gave two different answers. The DON indicated the resident did not have a true decline in his continence status. The DON indicated the resident should have been placed on a toileting program to maintain his continence status. The resident was occasionally incontinent and sometimes he would be able to tell staff when he needed to use the restroom. The "choosing a program that fits the resident after evaluation/assessment" policy provided by the Administrator on 5/11/16 at 10:55 a.m., indicated an scheduled toileting/habit training was for a resident with no pattern of urinary incontinence due to functional or transient incontinence then schedule the residents toileting at regular intervals to increase continent episodes per habit such as upon arising, before and after			

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	meals and before going to bed. "Scheduled toileting is a timed voiding, usually every three to four hours while awake. 3.1-41(a)(2)			