

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaints IN00182799 and IN00184407.</p> <p>Complaint IN00182799 - Unsubstantiated due to lack of evidence. Complaint IN00184407 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: October 26-30, and November 2, 4, and 5, 2015</p> <p>Facility number: 012534 Provider number: 155792 AIM number: 201028420</p> <p>Census bed type: SNF: 13 SNF/NF: 125 Total: 138</p> <p>Census payor type: Medicare: 18 Medicaid: 88 Other: 32 Total: 138</p> <p>Sample: 7</p>	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review desk review in lieu of post survey revisit on or after December, 1 2015.	

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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F 0157 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 11/9/15 by 29479.</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically</p>			

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	<p>update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure a physician was notified regarding a resident's change in skin condition for 1 of 7 residents reviewed for physician notification (Resident #82).</p> <p>Finding includes:</p> <p>During an interview on 10/28/15 at 10:45 a.m., Unit Manager #1 indicated Resident #82 had an unstageable pressure ulcer (full thickness tissue loss in which actual depth of the ulcer is completely observed by slough and/or eschar in the wound bed) on his sacrum.</p> <p>On 10/30/15 at 1 p.m., Resident #82's record was reviewed. The admission Minimum Data Set (MDS) assessment, dated 4/9/14 indicated Resident #82 was at risk for pressure ulcers, did not have pressure ulcers, was frequently incontinent of bladder and bowel, and required extensive assist of two for bed mobility, transfers, and toileting.</p> <p>The form titled, "ASC New Skin Event," dated 7/30/15 at 7:56 a.m., indicated Resident #82 had a new wound on his left butt cheek and was originally noted</p>	F 0157	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <ul style="list-style-type: none"> ·Resident # 82 physician was notified of change in resident's skin condition <p>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. ·All licensed nurses will be in-serviced on the Change in Condition policy provided by DNS/designee by December 1, 2015 ·A skin sweep will be conducted by licensed nurses by 12-01-15 to identify any change in resident's skin condition. DNS will ensure per policy that all appropriate physician notification related to change in skin conditionis done by December 1, 2015 <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur:</p> <ul style="list-style-type: none"> ·All licensed nurses will be in-serviced on the Change in Condition policy provided by DNS/designee by December 1, 2015 	12/01/2015	

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	<p>on 7/30/15. The form indicated the wound measurement was "pin point."</p> <p>A note added on 8/9/15 to the form titled, "IDT Weekly Update Skin Events," dated 7/31/15, indicated Licensed Practical Nurse (LPN) #10 had assessed the resident's wound and it measured 1 centimeters (cm) x 0.75 cm x less than 0.1 cm. The note indicated the increased size of the wound was discovered during peri care and barrier cream was applied. The note lacked documentation of physician notification.</p> <p>During an interview on 11/04/15 at 3:46 p.m., the Director of Nursing (DON) indicated Licensed Practical Nurse (LPN) #10 should have made a new skin event which would have triggered a physician notification for a new order of treatment, and then the Interdisciplinary Team (IDT) would have evaluated the area for staging.</p> <p>During an interview on 11/04/15 at 4:14 p.m., Licensed Practical Nurse (LPN) #10 indicated a Certified Nursing Assistant (CNA) discovered the resident's wound on his buttocks had increased in size during peri care. He indicated the CNA had wiped skin away during peri care. LPN #10 indicated he measured the wound after he was notified and added a</p>		<p>·Charge Nurses will give and receive report at change of shift Any changes in resident condition will be reported at that time. The ongoing nurse will review the facility activity report to identify and ensure prompt MD notification has occurred. If not, MD notification will be made immediately.</p> <p>·Weekly summaries/skin assessments, new skin events, and facility activity report will be reviewed daily by DNS/designee to ensure physician notification is made for changes in skin condition per facility policy.</p> <p>How corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place and</p> <p>·Change of Condition, and Skin Management CQIs will be completed weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and Medical Director. If threshold of 95% is not achieved an action plan will be developed.</p>		

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F 0164 SS=D Bldg. 00	<p>note to the existing skin note. He indicated he had added a note instead of creating a new skin note because the area was less than a centimeter in size, and he did not consider it a new area. LPN #10 indicated he should have notified the physician to determine the appropriate treatment.</p> <p>On 11/5/15 at 9:00 a.m., the Executive Director provided the current policy titled, "Resident Change of Condition." The policy indicated the nurse was to document the change in condition in the medical record and notify the physician promptly. The policy indicated the nurse in charge was to notify the physician prior to the end of his assigned shift.</p> <p>3.1-5(a)(2)</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a</p>				

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	<p>private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure privacy of dietary information for 1 of 1 resident reviewed for privacy (Resident #177).</p> <p>Finding includes:</p> <p>During the dining observation on 10/26/2015 at 12:21 p.m., the Executive Director was overheard speaking to the Dietary Manager regarding Resident #177's diet order and pointing at the resident from across the room. The Dietary Manager was overheard stating to the Executive Director, "I don't know. She's new. I can't know what she needs when I don't know her name."</p>	F 0164	<p>F164 Privacy and Confidentiality</p> <p>It is the practice of this provider to ensure residents have the right to personal privacy and confidentiality of his or her personal and clinical record, accommodations, medical treatment, written and telephone communications, personal care, visits, and meeting of family and resident groups. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> -Resident #177 has the privacy of her dietary information maintained. -The Dietary Manager is no longer employed with this facility 	12/01/2015

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	<p>During the dining observation on 10/26/2015 at 12:23 p.m., Resident #177 was observed without a drink at her lunch table. The Dietary Manager was observed to have finished passing out drinks to residents eating in the dining room and walk past Resident #177, stating aloud to resident, "We're finding out about you and then we'll get you your drinks." At 12:27 p.m., the Dietary Manager was then observed to approach Resident #177 by leaning her upper body on the dining room table, with her right arm resting on the table and requesting the resident's name. She was then observed to walk across the room to the kitchen door and state Resident #177's name aloud into the kitchen. She could be overheard stating this from across the room. At 12:29 p.m., Resident #177 was then observed to receive 2 glasses of thickened liquid.</p> <p>Resident #177's record was reviewed on 10/26/2015 at 3:45 p.m. A Minimum Data Set (MDS) assessment, dated 9/2/2015 indicated Resident #177 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 5 out of 15. She required extensive assistance of 1 staff member with eating.</p> <p>During an interview on 10/26/2015 at 12:26 p.m., Resident #177 indicated she</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice ·All staff will be in-serviced on resident rights including privacy and confidentiality of his or her personal and clinical records by the CEC/designee by December 1, 2015 <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All staff will be in-serviced on resident rights including privacy and confidentiality of his or her personal and clinical records by the CEC/designee by December 1, 2015 ·ExecutiveDirector/designee will conduct rounds and monitor dining rooms every meal to ensure that privacy of dietary information is maintained using Management Rounds Tool <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Dignity and Privacy CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee 		

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	<p>was thirsty and didn't have her drinks.</p> <p>During an interview on 10/28/2015 at 10:51 a.m., Resident #177 indicated she could overhear the Executive Director and Dietary Manager speaking about her in the dining room and it had upset her.</p> <p>During an interview on 11/05/2015 at 10:04 a.m., the Executive Director indicated staff should not speak loudly about a resident's medical information so that it could be overheard by others.</p> <p>On 11/2/2015 at 8:40 a.m., the Executive Director indicated the facility did not have a specific policy related to privacy of resident's medical information in dining areas.</p> <p>The State Operations Manual for Long Term Care Facilities, revised on 4/4/14 section, "ss483.10(e) Resident Rights: Privacy and Confidentiality," stated, "the resident has the right to personal privacy and confidentiality of his or her personal and clinical records...Personal privacy includes accomodations, medical treatment..."</p> <p>3.1-3(p)(2)</p>		<p>overseen by the Executive Director.</p> <p>·If a threshold of 95% is not achieved,an action plan will be developed to ensure compliance</p>		

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F 0241 SS=D Bldg. 00	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure staff conversations respected resident's dignity for 1 of 1 resident reviewed for dignity (Resident #91).</p> <p>Finding includes:</p> <p>During an observation on 10/27/2015 at 11:39 a.m., Resident #91 was observed in her wheel chair, receiving assistance with locomotion by propelling her wheel chair by Physical Therapist (PT) #3. Physical Therapist #3 was overheard stating to another staff member, "She's just being lazy today."</p> <p>Resident #91's record was reviewed on 10/29/2015 at 10:00 a.m. A Minimum Data Set (MDS) assessment, dated 10/7/2015, indicated the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 10 out of 15. She required extensive assistance from one staff member for locomotion on the unit. She had a wheelchair for mobility and impairment on both sides of</p>	F 0241	<p>F241 DIGNITY AND RESPECT OF INDIVIDUALITY It is the practice of this facility to promote care for residents in a manner and an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #91 was interviewed utilizing the QIS for dignity and denies staff mistreatment. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents who reside in this facility have the potential to be affected by the alleged deficient practice Staff will be in-serviced by the CEC or designee on resident rights including dignity and respect to ensure that staff conversations respect resident's dignity by December 1, 2015. <p>What measures will be put into place or what systemic changes you will make to</p>	12/01/2015

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F 0242 SS=D	<p>her lower extremities.</p> <p>During an interview on 11/4/2015 at 11:10 a.m., PT #3 indicated Resident #91 had received therapy from her on 10/27/2015 and it had not been appropriate to indicate to another staff member that Resident #91 was being "lazy."</p> <p>During an interview on 11/4/2015 at 11:30 a.m., Resident #91 indicated she overheard PT #3 tell another staff member she had been "lazy" and it had upset her.</p> <p>On 11/2/2015 at 8:40 a.m., the Executive Director indicated the facility did not have a specific policy related to dignity.</p> <p>The State Operations Manual for Long Term Care Facilities, revised on 4/4/14 section, "ss483.15(a) Quality of Life: Dignity," stated, "staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth."</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO</p>		<p>ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Staff will be in-serviced December 1, 2015 by Staff Development Coordinator or designee on resident rights including dignity and respect to ensure that staff conversations respect all residents' dignity ·Director of Nursing or designee will conduct rounds on all shifts to ensure that staff conversations respect all residents' dignity using Management Rounds Tool. ·The family members of residents that are cognitively impaired will be contacted and interviewed monthly by the Customer Care Representatives regarding the resident's dignity by using the QIS questions for dignity. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Dignity and Privacy CQI tool will be completed for ten residents on each unit weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. ·If a threshold of 95% is not achieved,an action plan will be developed to ensure compliance 		

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Bldg. 00	<p>MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident's preferences regarding wake up times were assessed for 1 of 3 residents reviewed regarding choices (Resident #180).</p> <p>Finding includes:</p> <p>During an interview on 10/28/2015 at 11:38 a.m., Resident #180 indicated she did not get to choose when staff woke her in the morning. She indicated the staff woke her up at 5 a.m. and she would like to sleep until 7 a.m.</p> <p>Resident #180's record was reviewed on 11/2/2015 at 9 a.m. A Minimum Data Set assessment (MDS), dated 8/11/2015 indicated Resident #180 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 7 out of 15 and required extensive assistance from 2 people with transfers. An MDS dated 12/8/2014 indicated it was very important for Resident #180 to choose her own bedtime.</p>	F 0242	<p>F242 SELF-DETERMINATION – RIGHT TO MAKE CHOICES It is the right of the resident to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility at are significant to the resident.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #180 care plan and preferences has been updated to include resident's preference for wake up time <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice ·Facility customer care representatives will interview their assigned residents or families utilizing the 'Preferences for Daily 	12/01/2015
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	<p>During an interview on 11/2/2015 at 12:01 p.m., Certified Nursing Assistant (CNA) #2 indicated Resident #180 was on the "Night Shift" get up list and the night shift staff woke her before 6 a.m.</p> <p>During an interview on 11/2/2015 at 12:21 p.m., the Activities Director indicated she could not provide documentation that Resident #180's preference for wake up time had been assessed. She indicated Resident #180's preferences should have been assessed on admission, quarterly and annually.</p> <p>A policy titled "Preferences for Daily Routines" dated 11/2011, and identified as current by the Executive Director on 11/5/2015 at 11:11 a.m., indicated, "...Activity or designee will complete the Preferences for Customary Routines worksheet upon admission of a new resident, quarterly and upon significant change of a resident...The information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences...."</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>		<p>Customary Routines' questionnaire to evaluate for resident preferences by December 1, 2015</p> <ul style="list-style-type: none"> Once preferences are identified by the customer care representative, appropriate departments will be notified and resident care plan and/or clinical record will be updated accordingly to ensure resident preferences are honored by December 1, 2015 Staff will be in-serviced by the CEC and/or designee including resident rights and preferences for daily routines by December 1, 2015 <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Staff will be in-serviced by the CEC and/or designee including resident rights and preferences for daily routines by December 1, 2015 Activity Director or designee will utilize the 'Preferences for Daily Customary Routines' questionnaire for all new residents, quarterly, annually, and with significant change for all residents. The AD will notify the Interdisciplinary Team to update resident care plan/clinical record accordingly, the ED will oversee compliance Customer care representative will follow up with residents and/or families monthly to ensure 				

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F 0244 SS=D Bldg. 00	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review, the facility failed to respond to grievances discussed in 2 of 6 Resident Council Minutes reviewed (June and July 2015 Council Minutes).</p> <p>Findings include:</p>	F 0244	<p>preferences are honored and the Interdisciplinary Team will update resident care plan/clinical record accordingly. The ED will ensure compliance.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Accommodation of Needs CQI tool will be completed by Activity Director or designee weekly x 4 weeks, monthly x 6 months, and quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance <p>F244 LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION It is the responsibility of the facility to listen to the views and act upon grievances of resident and families groups concerning proposed policy and operational decisions affecting resident care and life in the facility.</p>	12/01/2015

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	<p>The Resident Council meeting minutes for March 2015 to August 2015 were reviewed on 11/4/2015 at 9:35 a.m. Resident Council minutes, dated 6/30/15, indicated concerns the facility did not have enough Certified Nursing Assistants (CNA) to provide care to the residents, and concerns with dietary service. Resident Council minutes, dated 7/21/15, indicated concerns of poor CNA coverage and long waits for response to call lights. The minutes lacked documentation that nursing and dietary concerns expressed during the 6/30/2105 meeting, and nursing concerns expressed during the 7/21/2015 meeting, had been followed up by the facility.</p> <p>During an interview on 11/4/2015 at 1:41 p.m., the Resident Council President indicated the group's nursing and dietary concerns expressed during the Resident Council meetings had not been addressed by the facility.</p> <p>During an interview on 11/4/2015 at 3:05 p.m., the Activities Director indicated she attended the Resident Council meetings and filled out a meeting follow up form with the group's concerns. She indicated she provided the department heads with the concerns and they had 72 hours to respond. She indicated she could not</p>		<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·June Resident Council Minutes have been followed up on and reviewed with the Resident Council President ·July Resident Council Minutes have been followed up on and reviewed with the Resident Council President <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. ·The Executive Director completed an audit on all resident council minutes. A plan of action has been developed. ·Department Mangers will be in-serviced on the Resident Council Policy and Procedure by the Social Services Consultant/Executive Director by December 1, 2015. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?.</p> <ul style="list-style-type: none"> ·All Department Mangers will be in-serviced on the Resident Council Policy and Procedure by the Social Services Consultant/Executive Director by December 1, 2015 		

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F 0248 SS=D	<p>provide documentation of follow up for the concerns addressed in the 6/30/2015 and 7/21/2015 council meetings.</p> <p>During an interview on 11/5/2015 at 9:57 a.m., the Director of Nursing (DON) indicated the Resident Council meeting concerns should have been addressed by the nursing and dietary departments.</p> <p>A policy titled "Resident Council" dated 3/2012, identified as current by the Executive Director on 11/5/15 at 11:11 a.m., indicated, "...The council will be used to communicate concerns, give suggestions for future programming and events, and otherwise participate in and guide facility life...Concerns or suggestions from the meeting will be addressed by the appropriate department. The Executive Director will review all minutes and concerns...The facility responses to concerns/suggestions will be reviewed by the Resident Council President and the resident council on their next meeting...."</p> <p>3.1-3(l)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF</p>		<p>·Resident Council Meeting Minutes will be taken by the Activity Director monthly, and per Resident Council request. The Activity Director will then generate Resident Council Meeting Follow Up and distribute to the appropriate department head that same day. The Executive Director will oversee that this is done.</p> <p>·The Executive Director will ensure that all concerns voiced at the Resident Council Meeting were appropriately addressed within 7 days by signing the Resident Council Meeting Follow Up Form and presenting it to the Resident Council President for signature</p> <p>The Activity Director will ensure that resident council grievances have been reviewed and accepted on the next Resident Council Meeting and documented on the Resident Council Meeting Minutes which will be reviewed and signed by the Resident Council President and Executive Director monthly</p>		

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Bldg. 00	<p>EACH RES</p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents with cognitive impairment were provided with activities designed to meet their interest and their physical, mental, and psychosocial well being for 2 of 4 residents reviewed for activities (Residents #112 and #129).</p> <p>Findings include:</p> <p>1. Resident #112's record was reviewed on 10/29/2015 at 11:26 a.m. Resident #112 had diagnoses which included, but were not limited to, dementia and depression. A Minimum Data assessment tool (MDS), dated 9/15/15, indicated Resident #112 had severe cognitive impairment with a Brief Interview for Mental Status score (BIMS) of 00 out of 15 and was dependant on staff for locomotion and transfers.</p> <p>During observations on 10/29/15 from 11:13 a.m. to 11:26 a.m. Resident #112 was observed seated in the activity/dining room with her head to her chin and her</p>	F 0248	<p>F248 ACTIVITIES MEET INTEREST/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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #112 is encouraged to participate in activities per plan of care. ·Resident #129 is encouraged to participate in activities per plan of care. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All resident with cognitive impairment have the potential to be affected by the alleged deficient practice ·Activities staff will be in-serviced by the Social Services Consultant/designee by December 1, 2015 on the Activities Assessment Policy and Procedure on development of 	12/01/2015

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	<p>eyes closed. During this time two staff was observed leading a music/exercise activity in the activity/dining room. The staff was not observed to encourage Resident #112 to participate in the activity.</p> <p>During an observation on 10/29/15 from 1:30 p.m. to 1:47 p.m., Resident #112 was observed seated alone at a table in the Activity/Dining room with her head in her hand and her eyes opened. An activity staff was observed to pull the table away from Resident #112 without acknowledging her. Resident #112 was left seated in a chair isolated from the group of residents observed participating in a Bingo activity. Staff was not observed to acknowledge or engage her in conversation or encourage her to participate in the activity. At 1:47 p.m., staff assisted Resident #112 out of the Activity/Dining room and into her room.</p> <p>During an observation on 10/29/15 at 1:58 p.m., Resident #112 was observed lying on her back in bed, eyes opened looking towards the ceiling, with no music or television provided.</p> <p>During an observation on 10/30/2015 at 10:30 a.m. Resident #112 was observed seated in the Activity/Dining room with her head in her hand and her eyes closed.</p>		<p>activities to meet cognitively impaired residents interest and their physical, mental, and social well being</p> <ul style="list-style-type: none"> ·All residents with cognitive impairment will have their care plan reviewed updated accordingly to ensure that activities to meet their interest and their physical, mental, and social well being by the Activity Director/designee by December 1, 2015 <p>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Activities shall will be in-serviced bythe Social Services Consultant/designee by December 1, 2015 on the Activities Assessment Policy and Procedure on development of activities to meet cognitively impaired residents interest and their physical, mental, and socialwell being ·All residents with cognitive impairment will have their care plan reviewed updated accordingly to ensure that activities to meet their interest and their physical, mental, and social well being by the Activity Director/designee quarterly, annually, and with significant change ·The Executive Director/designee will make rounds daily to ensure that residents are engaged in 	

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	<p>An interactive question/answer activity was observed occurring in the Activity/Dining room at this time. Staff was not observed to encourage participation in the activity. At 10:36 a.m., staff assisted her out of the Activity/Dining room and into her room.</p> <p>During an observation on 10/30/2015 at 11:07 a.m., while a sing along activity was occurring in the Activity/Dining room. Resident #112 was observed lying on her back in bed, eyes opened and looking toward the ceiling, with no music or television provided.</p> <p>During an observation on 10/30/2015 at 11:27 a.m., while the sing along activity continued, Resident #112 was observed lying in her bed on her back, eyes opened and looking towards the ceiling, with no music or television provided.</p> <p>A Minimum Data Set assessment tool (MDS), dated 3/26/15, indicated Resident #112's family was interviewed regarding her activity preferences. The MDS indicated it was somewhat important for her to listen to music, read books and magazines, do things with groups of people, participate in her favorite activities, participate in religious activities, and go outside for fresh air when the weather was nice.</p>		<p>activities and encouraged to participate using the using the Management Rounds Tool.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Activities CQI tool will be completed weekly x 4 weeks, monthly x 6 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. 		

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	<p>A progress note dated 9/15/15 at 2:40 p.m., indicated Resident #112 needed much encouragement to attend and participate in group activities and she passively participated in most that she attended.</p> <p>An activity care plan dated 9/23/15, indicated Resident #112 required encouragement to attend and participate in activities and responded more often to sensory based activities. A goal indicated she would participate in social programming daily. Interventions to meet this goal included staff encouragement for her to attend and participate in activities, praise participation, encourage independent activity pursuits "particularly sensory based such as texture fabric swatches, tangles, balls, stress balls, snacks, music etc.," and assist to and from activities as needed.</p> <p>During an interview at 11/04/2015 at 11:30 a.m., The MCC (Memory Care Coordinator) indicated Resident #112 had declined since her last activity assessment and the current activity plan of care was not appropriate for her cognition level. She indicated Resident #112 would respond to staff interaction. She indicated staff brought her to</p>			

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	<p>activities but they weren't individualized to her needs. She indicated staff should have conversed with and encouraged her to participate. She indicated one on one activities were not provided to Resident #112.</p> <p>2. Resident #129's record was reviewed on 10/29/15 at 9:30 a.m. Resident #129 had a diagnosis which included, but was not limited to, dementia.</p> <p>During an observation on 10/28/15 at 11:11 a.m., Resident #129 was observed seated alone at a table in the Activity/Dining room. Other residents were engaged with activity staff and a music/exercise activity. Staff or residents were not observed encouraging Resident #129 to participate in the activity.</p> <p>During an observation on 10/26/2015 at 10:48 a.m., Resident #129 was observed seated alone at a table across the room from other residents who were participating in a riddle activity</p> <p>During observations on 10/29/2015 from 1:31 p.m. to 2:17 p.m., Resident #129 was observed in the Activity/Dining room. At 1:31 p.m., staff was observed clearing the noon meal dishes off the tables while activity staff was observed setting up the room for a bingo activity.</p>			

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	<p>Resident #129 remained seated at a table with another resident. Resident #129 and the other Resident were not observed interacting. Resident #129 had her eyes opened and was observed looking around the room. Staff or other residents were not observed interacting or encouraging Resident #129 to participate in the activity. At 1:59 p.m., Resident #129 was observed walking over to the table where the bingo game was occurring and sat in a chair at the table. Staff was not observed to acknowledge, engage, or encourage participation in the activity. Resident #129 was observed seated at the table with other residents and activity staff until 2:17 p.m. During this time staff was not observed to acknowledge, engage, or encourage participation in the activity. At 2:17 p.m., Resident #129 was observed walking out of the Activity/Dining room.</p> <p>A Minimum Data Set assessment tool (MDS), dated 5/3/15, indicated Resident had severe cognitive impairment with a Brief Interview of Mental Status (BIMS) score of 1 out of 15. The MDS indicated staff interviewed Resident #129 rather than an interested family member for activity preferences. Resident #129's response to all activity interest was "not important at all."</p>			

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	<p>An activity care plan, dated 8/12/15, indicated Resident #129 lacked a sense of imitative and needed to be encouraged and cued to attend activities. Interventions indicated staff would encourage her to attend and to become involved in the activity.</p> <p>During an interview on 10/30/2015 at 2:53 p.m., the Memory Care Coordinator indicated Resident #129's family was not queried regarding her activity preferences because Resident #129 could "verbalize" a response to the questions. She indicated she was passive for most activities but enjoyed being social.</p> <p>During an interview on 11/4/15 at 11:30 a.m., the Memory Care Coordinator indicated Resident #129's cognition had "significantly" declined but she would speak to and respond to people. She indicated she was ambulatory and would wander in and out of activities. She indicated one on one activities were not provided for Resident #129. She indicated the plan of care was not appropriate for her cognitive level. She indicated Resident #129 would wander in and out of activities but the activities were not individualized to meet her declined cognitive status. She further indicated staff should have interacted and encouraged her to participate.</p>			

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	<p>During an interview on 11/05/2015 at 11:08 a.m., Resident #129's family member indicated she visited Resident #129 consistently. She indicated Resident #129 had traveled all over the country, enjoyed 50's music, and race car sporting events. She indicated the last time she visited she was "slumped down in a chair" in the Activity/Dining room and "away from the crowd." She indicated she questioned the activity staff if they included her in the group activities and they reported to her they usually did no. She indicated Resident #129 would respond to touch and conversation and the longer you engaged her the more response you would get from her. She indicated staff has "never" asked her about Resident #129's activity interest.</p> <p>A policy titled "Activity Care Plan" identified as current by the Director of Nurses on 11/5/15 at 10:57 a.m., indicated, "...The activity department will develop a plan of care for each resident to address their specific activity needs and preferences. The activity staff will utilize resources such as Activity Assessment, Quarterly Activity Assessment, medical record and/or interview to develop a plan of care... The care plan will assist in carrying out activities meant to enhance well being and quality of life for each</p>			

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F 0279 SS=D Bldg. 00	<p>resident. The plan of care will identify the type of resident interests, preferences and abilities as well as any issues, concerns problems or needs affective the residents involvement/engagement in activities. Items to consider are continuations of life roles (hobbies/therapeutic work); development of new interests/hobbies/skills; connecting with community groups... The care plan will be revised based upon the following: changes in the resident's abilities, interest or health; revision of unsuccessful goals or interventions; resident interview; resident refusals; etc.</p> <p>3.1-33(a) 3.1-33(c)</p> <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</p>			

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	<p>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 review and revise pressure ulcer prevention and reduction interventions for 1 of 3 residents reviewed for care plan revision.</p> <p>Finding includes:</p> <p>During an observation on 10/30/15 at 3:33 p.m., the Assistant Director of Nursing (ADON) changed a dressing to Resident #82's sacral area. An unstageable pressure ulcer, that had been measured as 10.5 centimeters (cm) by 9 cm by 5.5 cm during a wound assessment on 10/29/15, was observed and had a small area where muscle and sloughing was visible at the base of the wound. The old dressing had scant amount of serosanguinous (containing or relating to both blood and the liquid part of blood) drainage. Pressure reducing boots were</p>	F 0279	<p>F 279 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>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #82 has had care plan revised and updated <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents with pressure ulcers have the potential to be affected by the alleged deficient practice ·A facility skin sweep will be conducted by licensed nurse by November 27, 2015 to identify all new pressure ulcers. All impairments in skin integrity will 	12/01/2015			

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	<p>in place.</p> <p>On 11/2/15 at 3:58 p.m., Resident #82 was positioned on his left side on a low air loss mattress. His feet were pressed against the footboard of the bed. Pressure reducing boots were in place. The Assistant Director of Nursing (ADON) changed the dressing on the resident's bilateral heels. The left heel had an unstageable pressure ulcer the size of a half dollar with black eschar (dead tissue) in the center of the wound. The right heel wound was the size of a quarter and had black eschar in the center. During the dressing change a new dime size open area was noted on the right foot below the little toe and an open area the size of a nickel was observed on the top of the right ankle. The resident was observed to have a dressing on the left lower leg and right medial knee.</p> <p>On 10/30/15 at 1 p.m., Resident #82's record was reviewed. Diagnoses included, but were not limited to: congestive heart failure, chronic ischemic heart disease, coronary artery disease, hypertension, hyperlipidemia, vitamin D deficiency, Alzheimer's disease, chronic kidney disease, hypokalemia, myoclonus, and edema.</p> <p>The admission Minimum Data Set</p>		<p>be evaluated by a Licensed Nurse and reported to Physician for appropriate treatment and interventions by November 27, 2015.</p> <ul style="list-style-type: none"> ·The Interdisciplinary Team will review and revise all residents with pressure ulcers physician's orders and care plans to ensure appropriate care plans are developed for pressure ulcer prevention and reduction by December 1, 2015 ·Licensed nurses will be in-serviced on the Skin Management Program by the CEC or designee by December 1, 2015 ·The Interdisciplinary Team will be in-serviced by the Home Office Nurse Consultant on the skin management program, IDT meeting requirements with resident with wounds, and care plan updating/review policy including revision in the plan of care if risk factors change, a new wound develops or wound deteriorates by December 1, 2015 <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Licensed nurses will be in-serviced on the Skin Management Program by the CEC or designee by December 1, 2015 ·The Interdisciplinary Team will be in-serviced by the Home Office Nurse Consultant on the skin 				

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	<p>(MDS) assessment, dated 4/9/14 indicated Resident #82 was at risk for pressure ulcers, did not have pressure ulcers, was frequently incontinent of bladder and bowel, and required extensive assist of two for bed mobility, transfers, and toileting.</p> <p>The form titled, "ASC Resident Assessment and Care Evaluation," dated 4/3/14 at 10:43 am, indicated the resident had no pressure ulcers and had the following risk factors for pressure: confined to bed or chair all or most of the time, persistently wet, fecal incontinence, immobility, and altered mental status.</p> <p>The form titled, "ASC New Skin Event," dated 7/30/15 at 7:56 a.m., Resident #82 had a new wound on his left butt cheek. The form indicated the wound measurement was "pin point" and a treatment order was to apply barrier cream every shift and as needed.</p> <p>The form titled, "IDT Weekly Update Skin Events," dated 7/31/15, indicated the resident had "moisture associated skin damage" on the left buttock measuring 0.6 centimeters (cm) x 0.5 cm x 0 cm. A note, added to the form on 8/9/15, indicated Licensed Practical Nurse (LPN) #10 assessed the resident's wound and it measured 1 cm x 0.75 cm x less than 0.1</p>		<p>management program, IDT meeting requirements with resident with wounds, and care plan updating/review policy including revision in the plan of care if risk factors change, a new wound develops or wound deteriorates by December 1, 2015</p> <ul style="list-style-type: none"> ·The Interdisciplinary Team will review all new and existing pressure ulcers weekly to ensure that current interventions are working, revise interventions if wounds are deteriorating, appropriate interventions are put into place, appropriate care plans are developed, and revised ·The wound nurse/designee will review all new pressure ulcers and develop care plans to address pressure reduction and risk factors daily. ·All residents found with new pressure ulcers or deteriorating wounds will have appropriate care plans put in place and revised with interventions to prevent further pressure ulcers and address pressure reduction daily by the wound nurse/designee and reviewed weekly by the IDT <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Skin Management Program CQI tool will be completed weekly x 4 weeks, monthly x 6 months and then quarterly for one year with results reported to the 				

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	<p>cm. The note indicated the increased size of the wound was discovered during peri care and barrier cream was applied.</p> <p>The Wound Care Specialists of Indiana (WCS) progress notes indicated the sacral wound was a stage 3 pressure ulcer, measuring 5.2 cm x 2 cm x 0.2 cm on 8/13/15. On 8/20/15, the wound measured 7.5 cm x 5.5 cm x 0.2 cm and on 8/27/15 was 9.5 cm x 6 cm x 0.2 cm. The wound was described as unstageable on 9/3/15 and measured 9 cm x 5 cm x 0.2 cm. The sacral wound increased in size to 10 cm x 5 cm x 0 cm. The sacral wound increased in size to 10 cm x 5 cm x 0.2 cm on 9/10/15.</p> <p>The WCS notes indicated an unstageable pressure ulcers on the left heel, measuring 1.8 cm x 1.5 cm x 0.1 cm, a stage 3 pressure ulcer measuring 3 cm x 1 cm x 0.1 cm, and an unstageable pressure ulcer on the left medial knee were discovered on 9/10/15.</p> <p>The WCS notes indicated the wounds on the right and left medial knees resolved on 9/17/15.</p> <p>The WCS notes, dated 10/22/15, indicated an unstageable pressure ulcer measuring 4.5 cm x 4.5 cm x 0.1 cm on the right medial heel, a stage 2 pressure</p>		<p>Continuous Quality Improvement Committee overseen by the Executive Director.</p> <p>If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance</p>		

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	<p>ulcer on the right medial knee, measuring 3.5 cm x 2.5 cm x 0.1 cm, and a stage 2 pressure ulcer on the left proximal medial lower leg, measuring 2.4 cm x 3 cm x 0.1 cm were present.</p> <p>The WCS notes, dated 10/29/15, indicated the pressure ulcer on the sacral area was unstageable and measured 10.5 cm x 9 cm x 5.5 cm. The left heel pressure ulcer was identified as unstageable, measuring 3.5 cm x 3.5 cm x 0.1 cm. The right medial heel had an unstageable pressure ulcer, measuring 3 cm x 3 cm x 0.1 cm. The pressure ulcer on the left proximal medial lower leg measured 4 cm x 2.5 cm x 0.1 cm and was unstageable. The right medial knee had an unstageable pressure ulcer, measuring 4.5 cm x 3 cm x 0.1 cm.</p> <p>The form titled, "ASC Pressure Wound Skin Evaluation Report," dated 11/3/15, indicated the resident had an unstageable with a suspected deep tissue injury on bottom of his right foot and the wound was found on 11/2/15. The form indicated the wound measured 2 cm x 1 cm x 0 cm.</p> <p>The form titled, "ASC Pressure Wound Skin Evaluation Report," dated 11/3/15, indicated the resident had an unstageable on his right lateral ankle and the wound</p>			

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	<p>was found on 11/2/15. The form indicated the wound measured 1 cm x 1.5 cm x 0.1 cm.</p> <p>A care plan for the resident's risk for skin breakdown was initiated on 4/3/14. Interventions included, but were not limited to: boots on bilateral feet, low air loss mattress, "Broda chair with Roho cushion," preventative treatments and supplements as ordered, "encourage resident to eat greater than 50% of meals," incontinence care, "turn and reposition at least every 2 hours," and weekly skin assessments. A bariatric low air loss mattress was added to the care plan on 9/8/15. The care plan did not indicate interventions for reducing pressure to the bilateral heels were revised after pressure ulcers developed in spite of the prevention plan.</p> <p>A care plan for the resident's impaired skin integrity and pressure ulcer was initiated on 8/4/15. The skin care plans' interventions included, but were not limited to: boots on bilateral feet, observe for signs and symptoms of infection, obtain labs as ordered, "assess for pain," low air loss mattress, "Broda chair with Roho cushion," treatments and supplements as ordered, "encourage resident to eat greater than 75% of meals," incontinence care, "turn and</p>			

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	<p>reposition at least every 2 hours," and assess and document skin weekly and notify physician of changes. The care plan did not indicate pressure reducing interventions for the bilateral heels were revised.</p> <p>The significant change MDS, dated 10/9/15, indicated the resident was occasionally incontinent of bladder, frequently incontinent of stool, had an indwelling catheter, was at risk for a pressure ulcer, had 4 unhealed pressure, and was an extensive assist of 2 for bed mobility, transfers, and toileting.</p> <p>During an interview on 10/28/15 at 10:45 a.m., Unit Manager #1 indicated Resident #82 had an unstageable pressure ulcer on his sacrum.</p> <p>During an interview on 11/2/15 at 4:07 p.m., the Assistant Director of Nursing (ADON) indicated she was unaware of the new open pressure ulcers below the little toe on bottom of the resident's right foot and the right lateral ankle.</p> <p>During an interview on 11/4/15 at 8:47 a.m., the Director of Nursing (DON) indicated pressure reducing interventions of turn and reposition every two hours, pressure relieving mattress on admission, incontinence care when needed,</p>			

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	<p>treatments according the physician orders, barrier creams and elevation of heels were implemented when a resident was identified with risk for developing skin breakdown. She indicated it was unfortunate Resident #82 developed pressure ulcers with the interventions in place.</p> <p>During an interview on 11/5/15 from 9:19 a.m., the DON indicated the efficacy of the interventions in place for residents with altered skin integrity or pressure ulcers was evaluated weekly in the IDT (Interdisciplinary Team) wound meetings. She indicated the Nurse Practitioner's wound notes were reviewed and efficacy of interventions was determined by whether the wound was healing, remained stagnant, or deteriorated. The DON indicated the intervention of pressure relieving boots was not effective since the resident developed pressure ulcers with the interventions in place and the intervention did not facilitate wound healing. She indicated the interventions should have been revised if a wound developed or deteriorated.</p> <p>On 11/4/15 at 9:10 a.m., the Executive Director indicated the facility did not have a specific policy related to care plans.</p>			

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F 0309 SS=D Bldg. 00	<p>On 11/4/15 at 11:03 a.m., the DON provided the current policy titled, "IDT weekly review of residents with wounds," dated 2/15. The policy indicated care plans related to wounds should be reviewed, " weekly in addition to writing an IDT note to ensure the documentation is current and reflects the interventions being utilized."</p> <p>3.1-35(d)(2)(B)</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure communication of care and health status for 1 of 1 residents reviewed for dialysis (Resident #223).</p> <p>Findings include:</p> <p>Resident #223's record was reviewed on 10/30/2015 at 3:00 p.m. The resident's diagnosis included, but was not limited to, renal failure and the record indicated</p>	F 0309	<p>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELLBEING 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</p> <p>What corrective action(s) will be accomplished for those residents found to have been</p>	12/01/2015

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	<p>the resident received hemodialysis three days a week.</p> <p>Resident #223's record lacked indication communication dialysis forms, which included pre-dialysis and post-dialysis assessments, had been completed by the facility and dialysis center for the resident's dialysis appointments from 10/14/2015 through 10/30/2015.</p> <p>Resident #223's record lacked indication an event called "Dialysis Appointment Assessment" had been initiated as an event within the electronic medical record for the dialysis appointment dates: 10/19/2015, 10/21/2015, and 10/26/2015.</p> <p>A nursing progress note, dated 10/30/2015 at 3:30 p.m., indicated, "UM [Unit Manager] called dialysis center to see if they had resident's dialysis binder due to it not being returned with her. Dialysis center does not have binder and does not remember the last time they had it. UM will create a new binder."</p> <p>During an interview on 10/30/2015 at 3:07 p.m., the Director of Nursing (DON) indicated the facility utilized a dialysis communication form within a dialysis binder. She indicated the facility sent the form with the resident to her dialysis appointments and reviewed for</p>		<p>affected by the deficient practice</p> <ul style="list-style-type: none"> Resident #223 has communication of care and health status with the dialysis center on dialysis days. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents that receive dialysis have the potential to be affected by the alleged deficient practice Licensed Nurses will be in-serviced by December 1, 2015 by the CEC or designee on Dialysis Care policy including communication of care and health status, completing dialysis appointment assessment pre and post dialysis appointment, sending pre-dialysis assessment with resident in dialysis binder, and reviewing dialysis return paperwork, and completing dialysis post assessment. Unit Managers reviewed all residents receiving dialysis to ensure that a communication binder was present by December 1, 2015 <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> Licensed Nurses will be in-serviced by December 1, 2015 by the CEC or designee on Dialysis Care policy including 				

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	<p>completion upon the resident's return. She indicated all dialysis communication forms were kept in a dialysis binder and if the resident returned without the form, she expected her staff to contact the dialysis provider and retrieve the missing information. She indicated she had been unable to locate the dialysis communication binder for Resident #223.</p> <p>During an interview on 11/2/2015 at 10:09 a.m., the DON indicated she could not provide any dialysis communication forms or dialysis assessments for Resident #223 from 10/14/2015 to 10/30/2015. She indicated the nursing staff should have ensured communication was done properly with the dialysis center.</p> <p>During an interview on 11/5/2015 at 9:48 a.m., the DON indicated a "Dialysis Appointment Assessment" for Resident #223 should have been initiated as an event within the electronic medical record by the nursing staff for the dates: 10/19/2015, 10/21/2015, and 10/26/2015.</p> <p>A policy titled "Dialysis Care" dated 1/2015, and identified as current by the DON on 11/2/2015 at 10:44 a.m., indicated, "...A dialysis event will be initiated in the EMR (Electronic Medical Records) to include time of transfer and</p>		<p>communication of care and health status, completing dialysis appointment assessment pre and post dialysis appointment, sending pre-dialysis assessment with resident in dialysis binder, and reviewing dialysis return paperwork, and completing dialysis post assessment.</p> <ul style="list-style-type: none"> ·Unit Manager or designee will audit dialysis events in Matrix, and check dialysis binders to ensure that pre and post dialysis assessments were completed and dialysis binder is present daily. ·Unit Manager or designee will contact dialysis center if post dialysis information is not returned and document post dialysis communication in the clinical record. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Dialysis CQI tool will be completed weekly x 4 weeks, monthly x 6 months, and then quarterly for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance 	

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F 0314 SS=G Bldg. 00	<p>completed on return to the unit...The nurse in charge at time of transfer to dialysis will provide the resident with all appropriate paperwork as required by the Dialysis Unit...The nurse in charge at time of return will review paperwork for new orders and/or paperwork accompanying the resident...An assessment of the resident will be completed upon return from each dialysis visit...."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to ensure pressure ulcer prevention and reducing interventions were evaluated and revised for a resident who entered the facility without pressure ulcers resulting in the development of a stage 3 (full thickness</p>	F 0314	F 314TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical	12/01/2015

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	<p>skin loss) pressure ulcer to the sacrum that later became unstageable and development of unstageable pressure ulcers (full thickness tissue loss in which actual depth of the ulcer is completely observed by slough and/or eschar in the wound bed) to the bilateral heels, right ankle, right foot, and the right and left medial knee for 1 of 3 residents reviewed for pressure (Resident #82).</p> <p>Finding includes:</p> <p>During an observation on 10/27/15 at 9:37 a.m., Resident #82 was sitting on a Roho cushion in a Broda chair. Pressure reducing boots were applied to the bilateral heels.</p> <p>During an observation on 10/28/15 at 10:31 a.m., Resident #82 was on his back on a low air loss mattress and a blanket covered his legs.</p> <p>During an observation on 10/29/15 at 1:52 p.m., Resident #82 was positioned on his right side with a pillow to support and maintain the position on a low air loss mattress. Pressure reducing boots were applied to the bilateral heels.</p> <p>During an observation on 10/29/15 at 3:46 p.m., Resident #82 was on his back on a low air loss mattress and a blanket</p>		<p>condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #82 was re-assessed and has pressure ulcer prevention and reducing interventions in place.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be effected by the alleged deficient practice ·A facility skin sweep will be conducted by licensed nurse by November 27, 2015 to identify all new pressure ulcers and assess current residents' risk factors, need for preventative skin interventions based on resident assessment. All impairments in skin integrity will be evaluated by a Licensed Nurse and reported to Physician for appropriate treatment and residents identified at risk will have preventative interventions put in place by November 27, 2015 ·Licensed nurses will be in-serviced on the Skin Management Program by the CEC or designee by December 1, 				

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	<p>covered his legs.</p> <p>During an observation on 10/30/15 at 3:33 p.m., the Assistant Director of Nursing (ADON) changed a dressing to Resident #82's sacral unstageable pressure ulcer, that had been measured as 10.5 centimeters (cm) by 9 cm by 5.5 cm during a wound assessment on 10/29/15. The wound had a small area where muscle and sloughing was visible at the base of the wound. The old dressing had scant amount of serosanguinous (containing or relating to both blood and the liquid part of blood) drainage. Pressure reducing boots were in place.</p> <p>During an observation on 11/2/15 at 1:40 p.m., Resident #82 was positioned on his left side with a pillow to support and maintain the position on a low air loss mattress and a blanket covered his legs.</p> <p>During an observation on 11/2/15 at 3:37 p.m., Resident #82 was positioned on his left side with a pillow to support and maintain the position on a low air loss mattress and a blanket covered his legs.</p> <p>On 11/2/15 at 3:58 p.m., Resident #82 was positioned on his left side on a low air loss mattress. His feet were pressed against the footboard of the bed. Pressure reducing boots were in place.</p>		<p>2015</p> <ul style="list-style-type: none"> ·The Interdisciplinary Team will be in-serviced by the Home Office Nurse Consultant on the skin management program, IDT meeting requirements with resident with wounds, and care plan updating including revision in the plan of care if a new wound develops, wound deteriorates, pressure wound risk factors, and pressure wound prevention by December 1, 2015 ·Licensed nurses and certified nurses aides will be checked off on skin check skills validation observed by CEC/Designee by December 1, 2015 <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Licensed nurses will be in-serviced on the Skin Management Program by the CEC or designee by December 1, 2015 ·The Interdisciplinary Team will be in-serviced by the Home Office Nurse Consultant on the skin management program, IDT meeting requirements with resident with wounds, and care plan updating including revision in the plan of care if risk factors change, a new wound develops, wound deteriorates, pressure wound risk factors, and pressure wound prevention by December 1, 2015 ·Skin sweeps will be done 		

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	<p>The Assistant Director of Nursing (ADON) changed the dressing on the resident ' s bilateral heels. The left heel had an unstageable pressure ulcer the size of a half dollar with black eschar (dead tissue) in the center of the wound. The right heel wound was the size of a quarter and had black eschar in the center. During the dressing change a new dime size open area was noted on the right foot below the little toe and an open area the size of a nickel was observed on the top of the right ankle. The resident was observed to have a dressing on the left lower leg and right medial knee.</p> <p>During an interview on 10/28/15 at 10:45 a.m., Unit Manager #1 indicated Resident #82 had an unstageable pressure ulcer on his sacrum.</p> <p>During an interview on 11/2/15 at 4:07 p.m., the Assistant Director of Nursing (ADON) indicated she was unaware of the new open pressure ulcers below the little toe on bottom of the resident's right foot and the right lateral ankle.</p> <p>During an interview on 11/4/15 at 8:47 a.m., the Director of Nursing (DON) indicated pressure reducing interventions of turn and reposition every two hours, pressure relieving mattress on admission, incontinence care when needed,</p>		<p>weekly by nurse managers and Director of Nursing or designee will ensure that prevention interventions are in place and residents are assessed for effectiveness of prevention interventions. Physician will be notified and orders obtained for treatment of any changes in skin condition noted, and prevention interventions</p> <ul style="list-style-type: none"> ·The DNS/designee will review all new admissions and re-admissions and assess their skin risk factors putting pressure reducing and prevention interventions in place daily, the care plan will be updated accordingly ·The IDT will review all pressure wounds weekly in the IDT meeting to review each wound and the effectiveness of the current intervention, and revise the plan of care based on the assessment. The DNS will ensure that pressure ulcer prevention and reducing interventions were evaluated weekly and revised if the pressure wound worsened. ·The DNS/designee will review the facility activity report daily to identify new wounds, change in skin condition, change in skin breakdown risk factors, and deterioration of wounds. The DNS/designee will re-evaluate the effectiveness of the current pressure wound interventions and revise the plan care ·The Unit Managers will review 		

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	<p>treatments according the physician orders, barrier creams and elevation of heels were implemented when a resident was identified with risk for developing skin breakdown. She indicated it was unfortunate Resident #82 developed pressure ulcers with the interventions in place.</p> <p>During an interview on 11/5/15 from 9:19 a.m., the DON indicated the efficacy of the interventions in place for residents with altered skin integrity or pressure ulcers was evaluated weekly in the IDT (Interdisciplinary Team) wound meetings. She indicated the Nurse Practitioner ' s wound notes were reviewed and efficacy of interventions was determined by whether the wound was healing, remained stagnant, or deteriorated. The DON indicated the intervention of pressure relieving boots was not effective since the resident developed pressure ulcers with the interventions in place and the intervention did not facilitate wound healing. She indicated the interventions should have been revised if a wound developed or deteriorated.</p> <p>During an interview on 11/4/15 at 2:42 p.m., the Nurse Practitioner (NP) indicated due to his comorbidities and immobility, Resident #82's pressure</p>		<p>shower sheets daily to ensure all areas identified have been communicated to the MD and new skin events have been initiated.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·A Skin Management Program CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director ·If 95% a threshold is not achieved, an action plan will be developed to ensure compliance 	

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	<p>ulcers were unavoidable. She indicated she kept a wound treatment in place for a few weeks and evaluated if it was effective. She indicated if a wound continued to deteriorate she typically would change the treatment after two weeks. She indicated Resident #82's wound had not improved and she was not expecting his wound to heal due to organ shut down and comorbidities.</p> <p>On 10/30/15 at 1 p.m., Resident #82's record was reviewed. Diagnoses included, but were not limited to: congestive heart failure, chronic ischemic heart disease, coronary artery disease, hypertension, hyperlipidemia, vitamin D deficiency, Alzheimer's disease, chronic kidney disease, hypokalemia, myoclonus, and edema.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 4/9/14 indicated Resident #82 was at risk for pressure ulcers, did not have pressure ulcers, was frequently incontinent of bladder and bowel, and required extensive assist of two for bed mobility, transfers, and toileting.</p> <p>The form titled, "ASC Resident Assessment and Care Evaluation," dated 4/3/14 at 10:43 a.m., indicated the resident had no pressure ulcers and had</p>			

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	<p>the following risk factors for pressure: confined to bed or chair all or most of the time, persistently wet, fecal incontinence, immobility, and altered mental status.</p> <p>The form titled, "ASC New Skin Event," dated 7/30/15 at 7:56 a.m., indicated Resident #82 had a new wound on his left butt cheek. The form indicated the wound measurement was "pin point" and a treatment order was to apply barrier cream every shift and as needed.</p> <p>The form titled, "IDT Weekly Update Skin Events," dated 7/31/15, indicated the resident had "moisture associated skin damage" on the left buttock measuring 0.6 centimeters (cm) x 0.5 cm x 0 cm. A note, added to the form on 8/9/15, indicated Licensed Practical Nurse (LPN) #10 assessed the resident's wound and it measured 1 cm x 0.75 cm x less than 0.1 cm. The note indicated the increased size of the wound was discovered during peri care and barrier cream was applied.</p> <p>The Wound Care Specialists of Indiana (WCS) progress notes indicated the sacral wound was a stage 3 pressure ulcer, measuring 5.2 cm x 2 cm x 0.2 cm on 8/13/15. On 8/20/15, the wound measured 7.5 cm x 5.5 cm x 0.2 cm and on 8/27/15 was 9.5 cm x 6 cm x 0.2 cm. The wound was described as unstageable</p>			

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	<p>on 9/3/15 and measured 9 cm x 5 cm x 0.2 cm. The sacral wound increased in size to 10 cm x 5 cm x 0. The sacral wound increased in size to 10 cm x 5 cm x 0.2 cm on 9/10/15:</p> <p>The WCS notes indicated an unstageable pressure ulcers on the left heel, measuring 1.8 cm x 1.5 cm x 0.1 cm, a stage 3 pressure ulcer measuring 3 cm x 1 cm x 0.1 cm, and an unstageable pressure ulcer on the left medial knee were discovered on 9/10/15.</p> <p>The WCS notes indicated the wounds on the right and left medial knees resolved on 9/17/15.</p> <p>The WCS notes, dated 10/22/15, indicated an unstageable pressure ulcer measuring 4.5 cm x 4.5 cm x 0.1 cm on the right medial heel, a stage 2 pressure ulcer on the right medial knee, measuring 3.5 cm x 2.5 cm x 0.1 cm, and a stage 2 pressure ulcer on the left proximal medial lower leg, measuring 2.4 cm x 3 cm x 0.1 cm were present.</p> <p>The WCS notes, dated 10/29/15, indicated the pressure ulcer on the sacral area was unstageable and measured 10.5 cm x 9 cm x 5.5 cm. The left heel pressure ulcer was identified as unstageable, measuring 3.5 cm x 3.5 cm</p>			

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	<p>x 0.1 cm. The right medial heel had an unstageable pressure ulcer, measuring 3 cm x 3 cm x 0.1 cm. The pressure ulcer on the left proximal medial lower leg measured 4 cm x 2.5 cm x 0.1 cm and was unstageable. The right medial knee had an unstageable pressure ulcer, measuring 4.5 cm x 3 cm x 0.1 cm.</p> <p>The form titled, "ASC Pressure Wound Skin Evaluation Report," dated 11/3/15, indicated the resident had an unstageable with a suspected deep tissue injury on bottom of his right foot and the wound was found on 11/2/15. The form indicated the wound measured 2 cm x 1 cm x 0 cm.</p> <p>The form titled, "ASC Pressure Wound Skin Evaluation Report," dated 11/3/15, indicated the resident had an unstageable on his right lateral ankle and the wound was found on 11/2/15. The form indicated the wound measured 1 cm x 1.5 cm x 0.1 cm.</p> <p>A care plan for the resident's risk for skin breakdown was initiated on 4/3/14. Interventions included, but were not limited to: boots on bilateral feet, low air loss mattress, "Broda chair with Roho cushion," preventative treatments and supplements as ordered, "encourage resident to eat greater than 50% of</p>			

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	<p>meals," incontinence care, "turn and reposition at least every 2 hours," and weekly skin assessments. The last new intervention added to the skin care plan was on initiated on 9/8/15, and was a, " Bariatric low air loss mattress. "</p> <p>A care plan for the resident's impaired skin integrity and pressure ulcer was initiated on 8/4/15. The skin care plans' interventions included, but were not limited to: boots on bilateral feet, observe for signs and symptoms of infection, obtain labs as ordered, "assess for pain," low air loss mattress, "Broda chair with Roho cushion," treatments and supplements as ordered, "encourage resident to eat greater than 75%of meals," incontinence care, "turn and reposition at least every 2 hours," and assess and document skin weekly and notify physician of changes. The last intervention was added on 10/12/15, and was for the Broda chair which was initiated on the skin breakdown care plan on 8/20/15.</p> <p>The forms titled, " Treatments Flowsheet, " for Resident #82 from 7/1/15 to 11/3/15 indicated the following treatments were ordered for the resident ' s sacral wound: From 6/9/15 to 8/31/15, " Calazyme to buttocks/coccyx and post upper thigh</p>			

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	<p>every shift. "</p> <p>From 7/30/15 to 8/4/15, " Cleanse with normal saline pat dry, apply Xeroform Occlusive Gauze Patch, cover with dry gauze, then tape in place, once a day. "</p> <p>From 8/20/15 to 8/26/15, " Vasolex (trypsin-balsam-castor oil) ointment; 90-87-788 unit-mg-mg/gram; amount to administer: thin layer; topical, every shift. "</p> <p>From 8/27/15 to 10/29/15, " Apply soap and water to sacral wound, apply 0.25% Dakins solution to gauze and wound, Use skin prep and apply ABD pads and tape, twice a day. "</p> <p>From 10/29/15 to 11/3/15, " Cleanse sacral wound with wound cleanser, 0.25 mg Dakin ' s soaked gauze to wound and change daily BID (twice a day). Cover with abd pad and optifoam sacrum wound dressing to wound on coccyx. "</p> <p>The significant change MDS, dated 10/9/15, indicated the resident was occasionally incontinent of bladder, frequently incontinent of stool, had an indwelling catheter, was at risk for a pressure ulcer, had 4 unhealed pressure, and was an extensive assist of 2 for bed mobility, transfers, and toileting.</p> <p>On 11/4/15 at 11:03 a.m., the DON provided the current policy titled, "IDT weekly review of residents with wounds,"</p>			

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F 0329 SS=D Bldg. 00	<p>dated 2/15. The policy stated, " the note should refer specifically to each site and be general whether the site has worsened, remained unchanged or improved. " The policy stated, " If the wound has worsened or improved the IDT note should reference these changes and credit or change the current interventions. "</p> <p>The policy indicated care plans related to wounds should be reviewed, " weekly in addition to writing an IDT note to ensure the documentation is current and reflects the interventions being utilized. "</p> <p>3.1-40(a)(2)</p> <p>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.</p> <p>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</p>			

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	<p>residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to review and consider a dose reduction when documentation did not indicate residents displayed behaviors for which the medications were prescribed for 2 of 5 residents reviewed for unnecessary medication (Resident #161 and #54).</p> <p>Findings included:</p> <p>1. Resident #161's record was reviewed on 10/29/2015 at 2:41 p.m. Resident #161 had diagnoses which included, but were not limited to, dementia, anxiety, and depression.</p> <p>A physician's order, dated 9/23/14, indicated an order for alprazolam (anti-anxiety) 0.5 Milligram (mg) scheduled daily at bedtime. The record lacked indication a gradual dose reduction of this medication had been attempted.</p> <p>A behavior care plan, dated 3/21/15, indicated Resident #161 had symptoms of anxiety and exhibited these symptoms with repetitive complaints of discomfort,</p>	F 0329	<p>F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #161 had a GDR of Remeron on 10/30/15. Xanax was reviewed by MD for GDR. ·Resident #54 had a GDR of Mirtazapine on 10/30/15. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who receive psychotropic medications have the potential to be affected by the alleged deficient practice. ·The IDT team will be in-serviced on the Psychoactive 	12/01/2015

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	<p>anxious repetitive request for medications, hand wringing, and negative statements. This care plan lacked indication antianxiety medications would be routinely reviewed and gradual dose reductions would be attempted if not contraindicated.</p> <p>Behavior monitoring records, dated January 2015 - July 2015 and September 2015 - October 2015, were reviewed. The records indicated Resident #161 exhibited zero signs/symptoms of anxiety.</p> <p>A document titled "...Request for Gradual Dose Reduction," dated 7/17/15, indicated the facility had requested from the physician to make an attempt to gradually reduce Resident #161's alpraxolam. The note indicated he declined due to she was receiving the optimal dose that benefited her function and activities of daily living. The note lacked indication as to why a gradual dose attempt was contraindicated.</p> <p>During an interview on 10/30/2015 at 11:01 a.m., Licensed Practical Nurse (LPN) #50 indicated Resident #161 at times would get anxious at bedtime but was easily redirected. She indicated a gradual dose reduction of the anti-anxiety medication had not been attempted</p>		<p>Medication Management and Behavior Management Programs by the Home Office Nurse Consultant by December 1, 2015</p> <ul style="list-style-type: none"> The IDT team reviewed all physician's orders in the clinical meeting to identify all residents receiving psychotropic medications to determine when the medication was initiated and when the last GDR was done or requested Social Services/designee and Memory Care Facilitator/Designee reviewed all residents receiving psychotropic medications to ensure that a GDR has been requested per facility policy and that there was resident specific behavior monitoring in place. Physician's disagreeing with a facility requested GDR will document in the clinical record why Gradual Dose Reduction is clinically contraindicated <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> The IDT team will be in-serviced on the Psychoactive Medication Management and Behavior Management Programs by the Home Office Nurse Consultant by December 1, 2015 The IDT team will review all physician's orders in the clinical meeting to identify all residents receiving psychotropic medications and ensure it is 		

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	<p>because Resident #161's "daughter wanted her to have it" due to "long time use and generalized anxiety."</p> <p>During an interview on 11/04/2015 at 9:10 a.m., the Administrator indicated behavior monitoring records for August 2015 for Resident #161 were not available.</p> <p>During an interview on 11/4/15 at 9:40 a.m., with the Administrator, Director of Nursing, and the Social Service Director (SSD) present, SSD indicated psychotropic medications were reviewed monthly and if residents were not having behaviors gradual dose reductions would be attempted.</p> <p>2. Resident #54's record was reviewed on 10/29/15 at 1:35 p.m. Resident #54 had diagnoses which included, but were not limited to, dementia and depression.</p> <p>A physician's order, dated 4/29/15, indicated an order for mirtazapine (anti-depressant) 30 Milligrams daily. The record lacked indication a gradual dose reduction of this medication had been attempted.</p> <p>A care plan, originally dated 12/6/13 and updated on 8/12/15, indicated Resident #54 was at risk for symptoms of</p>		<p>appropriate and relates to resident's specific behavior and update care plan accordingly. The medications will then be logged in the GDR tracking form daily M-F in the clinical meeting</p> <ul style="list-style-type: none"> ·All residents who are who are receiving psychotropic medications will have a behavior monitoring flow sheet to identify targeted behavioral symptoms being monitored as well as personalized non-pharmacological interventions Licensed nurses will document behaviors and/or symptoms. ·Social Services/designee and Memory Care Facilitator/Designee will review all residents receiving psychotropic medications to ensure that a GDR has been requested per facility policy. ·The Social Services Director/designee will review the behavior monitoring flowsheet and complete a behavior summary monthly ·During the monthly behavior meeting the IDT will evaluate behaviors, symptoms, and efficacy of the psychotropic medications by reviewing the behavior monthly summaries and request GDRs in the absence of behaviors ·Physician's disagreeing with a facility requested GDR will document in the clinical record stating why a Gradual Dose Reduction is clinically 				

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	<p>depressions evidenced by making comments of wanting to die or other negative comments. A goal for her indicated she would not have an increase of symptoms of depression. This care plan lacked indication anti-depressant medications would be routinely reviewed and gradual dose reductions would be attempted if not contraindicated.</p> <p>During an interview on 11/4/15 at 11:14 a.m., the Memory Care Coordinator indicated documentation of symptoms of depression was not available and staff had not reported that she had exhibited symptoms of depression. She indicated Resident #54 was social, not tearful, and ate well.</p> <p>A document titled "...Request for Gradual Dose Reduction," dated 6/12/15, indicated the facility had requested from the physician to make an attempt to gradually reduce Resident #54's alpraxolam. The note indicated he declined due to she was receiving the optimal dose that benefited her function and activities of daily living. The note lacked indication as to why a gradual dose attempt was contraindicated.</p> <p>A policy titled "Psychotropic Management Policy" identified as current by the Administrator on 10/30/15</p>		<p>contraindicated</p> <ul style="list-style-type: none"> ·Pharmacist will follow up on all facility requested GDRs monthly to ensure that appropriate follow up has occurred in monthly Pharmacy Consultant Report <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Psychoactive Management CQI tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. ·If 95% threshold is not achieved, an action plan will be developed to ensure compliance. 				

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	<p>at 2:42 p.m., indicated, "...It is the policy of American Senior Communities to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being. These medications are managed in collaboration with the attending physician, pharmacist and facility staff to include behavioral interventions, assessment and reduction as applicable. Procedure: Each resident receiving psychotropic medication will have a supporting diagnosis for us which is documented in the clinical record. Each resident receiving psychotropic medication will have an appropriate indication for use. Prior to initiating a psychotropic medication, an assessment will be made of the resident including other potential causes of the behavior which may include medical factors, pain, diagnoses. The facility will initiate a request for a Gradual Dose Reduction at least on the following schedule for each drug. For residents who use antipsychotic medication a GDR must be initiated per the following guidelines: During the first year that the resident is admitted to the facility on an antipsychotic or after the facility has initiated an antipsychotic, a GDR must be attempted in two separate quarters with at least one month in between attempts,</p>			

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	<p>unless clinically contraindicated by the physician. After the first year, a GDR must be attempted annually unless clinically contraindicated by the physician. For residents who use antidepressant medications a GDR must be initiated per the follow guideline: During the first year that the resident is admitted to the facility on an antidepressant or after the facility has initiated an antidepressant, a GDR must be attempted in two separate quarters with a least one month in between attempts, unless clinically contraindicated by the physician. After the first year, a GDR must be attempted annually unless clinically contraindicated by the physician... All residents who are taking antipsychotic, analytics, sedative/hypnotic, or anticonvulsant medication (used for behavioral indication) are required to have a behavior monitoring program in place identifying targeted behavioral symptoms being monitored as well as personalized non pharmacological interventions... The residents who are on the behavior program will be reviewed monthly for a quantification of behaviors and valuation of interventions. During the monthly review, there will also be a psychotropic medication review. The monthly Behavior and Psychoactive Review will be completed monthly and placed in the</p>			

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F 0371 SS=D Bldg. 00	<p>medical record. The signed GDR form should be filed under Physician's Progress Notes when completed. For all psychotropic medication order changes, the resident will be monitored for for 72 hours for any changes in symptoms or adverse effects."</p> <p>3.1-48(b)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure prepared foods were covered, dated and discarded by the use by date for 1 of 2 dietary observations. This had the potential to affect 138 of 138 residents who ate food from the kitchen.</p> <p>Findings include: During the initial dietary tour with the Dietary Manager on 10/26/15 at 10:48 a.m., the following was observed:</p>	F 0371	<p>F371 FOOD PROCURE, STORE/PREPARE/SERVE –SANITARY The facility must 1.Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and 2.Store, prepare, distribute and serve food under sanitary conditions What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·30 cups of pudding were discarded</p>	12/01/2015			

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	<p>a. 30 cups of prepared pudding were observed uncovered and without dates of preparation in the walk in refrigerator.</p> <p>b. 1 container of prepared mixed berries with a use by date of 10/23/15 and 1 container of diced ham with a use by date of 10/23/15 were observed stored in the walk in refrigerator.</p> <p>c. 2 cups of prepared ice cream cups were observed uncovered in the snack refrigerator.</p> <p>During an interview on 10/26/15 at 10:50 a.m., the Dietary Manager indicated the cups of prepared puddings should have been covered and dated. She indicated the prepared container of mixed berries and diced ham should have been discarded by the use by date of 10/23/15. She indicated the prepared ice cream cups stored in the snack refrigerator should have been covered.</p> <p>A policy titled "Food Storage" dated 7/2015, and identified as current by the Executive Director on 11/2/15 at 8:40 a.m., indicated, "...Leftover prepared foods are to be stored in covered containers or wrapped securely. The food must be clearly be labeled with the name of the product, the date it was prepared</p>		<p>·The container of mixed berries werediscarded</p> <p>·2 cups of prepared ice cream were discarded</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential to be effected by the alleged deficient practice</p> <p>·Dietary staff will be in-serviced on proper food storage and labeling by the Executive Director/designee by 12/1/15.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Dietary staff will be in-serviced on proper food storage and labeling by the Executive Director by 12/1/15.</p> <p>·The Certified Dietary Manager/designee will complete the Kitchen Sanitation/Environmental Review after each meal to ensure food is stored, dated and covered per facility policy.</p> <p>How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place?</p> <p>·A Kitchen Sanitation/Environmental Review tool will be utilized weekly X 4 weeks, monthly x 6 months, and quarterly thereafter for one year</p>		

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F 9999 Bldg. 00	<p>and marked to indicate the date by which the food shall be consumed or discarded. Leftover foods can be held at 41 degrees Fahrenheit or less for no more than 3 days. The day the food was prepared shall be counted as Day 1...."</p> <p>A policy titled "Use of Leftovers" dated 7/2015, and identified as current by the Executive Director on 11/2/15 at 8:40 a.m., indicated, "...Improperly stored leftovers will be thrown out...."</p> <p>3.1-21(i)(3)</p> <p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be</p>	F 9999	<p>with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director</p> <ul style="list-style-type: none"> ·In addition, a full sanitation audit will be conducted by the RD Consultant monthly ·If 95% a threshold is not achieved, an action plan will be developed to ensure compliance <p>·F9999 Final Observations</p> <ul style="list-style-type: none"> ·It is the practice of this provider to ensure that all alleged violations involving recertification of licensure are provided in accordance with State and Federal law through established procedures. ·What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? ·The tuberculin skin test was redone for COTA #4, RN #5, and CNA #6. ·How will you identify other residents having the potential 	12/01/2015

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	<p>documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 5 out of 5 employees had recorded tuberculosis screening results that included the times the screening was given and/or read, and failed to ensure 2 out of 5 employees' tuberculosis screening results included the millimeters of induration. This</p>		<p>to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by this alleged deficient practice. ·The Home Office Nurse Consultant will educate the Clinical Education Coordinator CEC and the Director of Nursing DNS on Employee Screening – Tuberculosis by 12/1/15. ·An audit was completed by the Executive Director of all staff PPD/TB screening by 12/1/15. Anyone not having a valid PPD will receive a new PPD by December 1, 2015. Staff not receiving their PPD will be removed from the schedule until administered. <p>What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·The Home Office Nurse Consultant will educate the Clinical Education Coordinator CEC and the Director of Nursing DNS on Employee Screening – Tuberculosis by 12/1/15. ·The CEC/designee will administer the PPD skin test per facility policy by 12/1/15 ·The time read will be added to the Employee Immunization Record by the Director of Clinical Education by 12/1/15 ·The CEC will complete a tickler file with all staff PPDs due each month. The form will be filled out completely and accurately per 		

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	<p>deficiency had the potential to effect 138 out of 138 residents residing at the facility.</p> <p>Findings include:</p> <p>On 11/5/15 at 12 p.m., five employee records were reviewed for proof of tuberculosis (TB) screening upon hire. State form 5440, "Employee Records," provided on 10/26/15 by the Administrator, indicated Certified Occupational Therapy Aide (COTA) # 4 began employment on 10/26/15.</p> <p>The human resources form titled, "Tuberculin Testing for Employees," for COTA #4 indicated she had the first step TB test on 4/6/15 at 10 a.m. and it was read on 4/8/15. The form indicated the second TB test was given on 4/16/15 and read on 4/18/15. No time was documented on 4/8/15, 4/16/15, or 4/18/15. No measurement of induration was documented for the second TB test read on 4/18/15.</p> <p>State form 5440, "Employee Records," provided on 10/26/15 by the Administrator, indicated Registered Nurse (RN) #5 started employment on 9/23/15.</p> <p>The human resources form titled,</p>		<p>facility policy. The ED will oversee this program to ensure that all PPDs were given when they were due and that the form was filled out completely and read per facility policy</p> <p>·How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·The Personnel and Confidential Employee File Checklist will be used on all new Employee files. ·The HR Coordinator/designee will review the checklist weekly. ·Any missing file information will be communicated with the employee and Department manager for immediate follow up. ·Home Office Consultant will complete a file audit every six months to ensure PPDs were administered and read per facility policy with results reported to the Continuous Quality Improvement Committee overseen by the Executive Director. ·If 95% threshold is not achieved, an action plan will be developed to ensure compliance. 	

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	<p>"Tuberculin Testing for Employees," for RN #5 indicated he had the first step TB test on 9/29/15 and it was read on 10/1/15. The form indicated RN #5 had a second TB test on 10/10/15 and it was read on 10/12/15. No time was documented on 9/29/15, 10/1/15, 10/10/15, or 10/12/15. No measurement of induration was documented for the second TB test read on 10/12/15.</p> <p>State form 5440, "Employee Records," provided on 10/26/15 by the Administrator, indicated Certified Nursing Assistant (CNA) #6 started employment on 9/12/15.</p> <p>The human resources form titled, "Tuberculin Testing for Employees," for CNA #6 indicated she had the first step TB test on 8/26/15 and it was read on 8/28/15. The form indicated CNA #6 had a second TB test on 9/3/15 and it was read on 9/5/15. No time was documented on 8/26/15, 8/28/15, 9/3/15, or 9/5/15.</p> <p>State form 5440, "Employee Records," provided on 10/26/15 by the Administrator, indicated Nursing Assistant (NA) #7 started employment on 7/15/15.</p> <p>The human resources form titled,</p>						

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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
	<p>"Tuberculin Testing for Employees," for NA #7 indicated she had the first step TB test on 7/10/15 and it was read on 7/13/15. The form indicated NA #7 had a second TB test on 7/19/15 and it was read on 7/21/15. No time was documented on 7/10/15, 7/13/15, 7/19/15, or 7/21/15.</p> <p>State form 5440, "Employee Records," provided on 10/26/15 by the Administrator, indicated Licensed Practical Nurse (LPN) #8 started employment on 8/11/15.</p> <p>The human resources form titled, "Tuberculin Testing for Employees," for LPN #8 indicated she had the first step TB test on 8/9/15 and it was read on 8/11/15. The form indicated LPN #8 had a second TB test on 8/21/15 and it was read on 8/24/15. No time was documented on 8/9/15, 8/11/15, 8/21/15, or 8/24/15.</p> <p>On 11/5/15 at 3:10 p.m., the daily nursing assignment schedules from 10/26/15 to 11/2/15 were reviewed, and indicated RN #5, NA #7, and LPN #8 had worked during this timeframe.</p> <p>During an interview on 11/05/15 at 12:55 p.m., the Director of Nursing (DON) indicated TB tests were time sensitive</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/05/2015
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	<p>and so the time the test was administered and read would be necessary on the documentation. She indicated she was unaware the TB tests for new hired staff did not have times documented.</p> <p>The "Employee Immunization Record: Tuberculin Skin Testing (TST)," form revised on 7/2015, stated, "The test must be read 48-72 hours after the initial injection." The form indicated if the test was not read within the approved time frame it was invalid and the test would have to be readministered.</p> <p>3.1-14(t)(1)</p>			