

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/26/2014
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NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 22, 23, 24, 25 and 26, 2014</p> <p>Facility number: 000081 Provider number: 155162 AIM number: 100289570</p> <p>Survey Team: Shelley Reed, RN TC Jason Mench, RN Angela Selleck, RN</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 7 Medicaid: 46 Other: 9 Total: 62</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	<p>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 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after October 10, 2014. We respectfully request a desk review in lieu of a post survey revisit.</p>	

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

TITLE

(X6) DATE

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

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure the Plan of Care was followed for 1 of 5 residents reviewed for unnecessary medication and interventions attempted for maladaptive behaviors. (Resident #55)</p> <p>Findings Include:</p> <p>The clinical record for Resident #55 was reviewed on 9/23/14 at 2:31 p.m. The record indicated diagnoses included, but were not limited to, dementia with behavioral disturbances, dementia with vascular delusion and depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 7/23/14, indicated Resident #55 was severely cognitively impaired.</p> <p>The current care plan, dated 7/30/14, indicated Resident #55 had identified problems related to unrealistic fears, delusions of family stealing his money</p>	F000250	<p>F250 PROVISION OF MEDICALLY RELATED SOCIAL SERVICE It is the policy of this facility to provide medically-related social services to attain or maintain the highest practical physical, mental and psychological 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 #55's behavior was documented into the tracking system. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents had the potential to have been affected by the alleged deficient practice. ·All residents who have exhibited maladaptive behavior on the Memory Care unit were reviewed by the Social Service team to ensure the care plan and behavior tracking system was applicable by October 10, 2014. 	10/10/2014

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	<p>and wanting to leave the facility. Approaches to the problem included, but were not limited to, "validate the issue that it would be upsetting, maintain a calm environment, offer resident to speak with daughter or redirect to another activity."</p> <p>During an interview on 9/25/14 at 10:00 a.m., the Memory Care Facilitator indicated Resident #55 had a behavior this morning. She indicated the resident had anxiety and fear related to family stealing from him. She indicated that he stated he needed to get home and had several clothing items packed and some pictures off the wall.</p> <p>During review of the Event Report sheet for Resident #55, dated 9/25/14 at 9:45 a.m., the Memory Care Facilitator indicated the behavior occurred in his bed room at approximately 7:35 a.m. The report indicated the resident told the nurse people were stealing his belongings and he had to get to his motorcycle before something happened to it. Resident #55 had taken all of his clothes off the hangers and put them onto his bed and removed wall hangings. The intervention on the Event Report indicated Resident #55 was kept in an activity in the common dining room following the behavior.</p>		<ul style="list-style-type: none"> ·All staff will be in-serviced on the facility ASC Behavior Management Policy & Procedure. Education will be provided by the Clinical Education Coordinator/Designee and completed by October 10, 2014. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·All staff will notify the nurse on duty when a behavior occurs to ensure the tracking system reflects the behavior displayed and plan of care followed. ·Social Services will review the tracking system to ensure the documentation is accurate during IDT meeting. ·Social Service Department will receive one-on-one training by the Social Service Consultant/Designee on the facility ASC Behavior Management Policy & Procedure by October 10, 2014. ·All staff will be in-serviced on the facility ASC Behavior Management Policy & Procedure. Education will be provided by the Clinical Education Coordinator/Designee and completed by October 10, 2014. 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; and 	

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	<p>During review of the Behavior Administration report, from 9/21/14 through 9/25/14, the report indicated the resident had demonstrated no maladaptive behaviors for the days listed.</p> <p>During an interview on 9/26/14 at 10:37 a.m., the Director of Nursing (DoN) indicated the nurse on duty should have documented the behavior into the tracking system and the interventions that were used and if they were effective or not.</p> <p>Review of a current facility undated facility policy titled "ASC Behavior Management Policy & Procedure", which was provided by the Administrator on 9/26/14 at 1:10 p.m., indicated the following;</p> <p>" Policy: It is the policy of ...</p> <p>...Procedure:</p> <p>1. Care plans ...</p> <p>...4. When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records or signs off on the behavior on the monitoring form including what interventions were attempted during the episode and whether</p>		<ul style="list-style-type: none"> · A CQI monitoring tool called BehaviorManagement CQI will be utilized every week x 4 and Monthly x 6. · Data will be collected by DNS/Designeeand submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed. · Non-Compliance with facility proceduremay result in disciplinary action up to and including termination. by what date thesystemic changes will be completed - October 10, 2014 				

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F000279 SS=D	<p>or not they were effective. "</p> <p>3.1-34(a)</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 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 interview and record review, the facility failed to ensure a comprehensive care plan was developed for impaired vision for 1 of 3 residents reviewed for vision in a total sample of 22 residents who had care plans reviewed. (Resident #39)</p> <p>Findings include:</p>	F000279	F279 DEVELOP COMPREHENSIVE CARE PLANS It is the policy of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive care plan. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/10/2014

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	<p>Resident #39 clinical record was reviewed on 9/24/14 at 10:06 a.m. Current diagnoses included, but were not limited to, depression, urinary retention and hypertension.</p> <p>Resident #39 had an Minimum Data Set (MDS) assessment dated 9/8/14 which indicated he was cognitively intact.</p> <p>During an interview with Resident #39 on 9/24/14 at 11:00 a.m., he indicated that he had worn glasses for years. During the interview it was noted that he had his glasses on his lap with a set of papers and when asked about them, the resident stated he had been reading.</p> <p>During an interview with the Minimum Data Set assessment (MDS) Coordinator, on 9/24/14 at 10:55 a.m., she indicated Resident #39 had MDS assessments on 8/7/14 and 8/12/14 and had adequate vision on those assessments while wearing his glasses. On 8/26/14, 9/8/14 and 9/13/14 Resident #39 had assessments showing impaired vision while not wearing his glasses. The MDS Coordinator indicated Resident #39 had worn glasses since he was admitted and should have had a care plan for impaired vision, but one could not be found.</p>		<ul style="list-style-type: none"> · Resident # 39 has been care planned for visual impairment. · Social Service department received training about formulating a care plan for residents with inadequate vision by October 10, 2014. how other residents having the potential to be affected by the same deficient practice will be identified and what correctiveaction(s) will be taken; · All residents have the potential to be affected by the alleged deficient practice. · All resident care plans will be audited by MDS Coordinator to ensure a vision care plan is in place for visually impaired residents by October 10, 2014. · Interdisciplinary team will be in-serviced on care planning for inadequate vision. Education will be provided by the Director of Nursing/Designee and completed by October 10, 2014. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · Care Plans will be reviewed upon admission and quarterly thereafter to ensure residents who display visual inadequacy have a corresponding care plan. · Reviews will be conducted by MDS coordinator/designee. · Interdisciplinary team will be in-serviced on care planning for visual inadequacy on or by October 10, 2014. Education will 		

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F000282 SS=D	<p>Review of "IDT Care Plan Review", provided by the Director of Nursing on 9/26/14 at 1:15 p.m., indicated:</p> <p>"Policy: It is the policy of this facility that each resident will have a comprehensive care plan developed based on comprehensive assessment. The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs..."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure the Plan of Care was followed for 1 of 5 residents reviewed for unnecessary medication and interventions attempted for maladaptive behaviors. (Resident #55)</p> <p>Findings Include:</p>	F000282	<p>be provided by the Director of Nursing/Designee. howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and</p> <ul style="list-style-type: none"> ·A CQI monitoring tool called Care Plan Updating CQI will be utilized every week x 4 and Monthly x 6. ·Data will be collected by DNS/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, anaction plan will be developed. ·Non-Compliance with facility procedure may result in disciplinary action up to and including termination. by what date thesystemic changes will be completed. October 10, 2014 <p>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN It is the policy of this facility to ensure that all residents are taken care of according to the resident's personal plan of care. what correctiveaction(s) will be accomplished for those residents found to have been affected by the deficient practice;</p>	10/10/2014

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	<p>The clinical record for Resident #55 was reviewed on 9/23/14 at 2:31 p.m. The record indicated diagnoses included, but were not limited to, dementia with behavioral disturbances, dementia with vascular delusion and depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment, dated 7/23/14, indicated Resident #55 was severely cognitively impaired.</p> <p>The current care plan, dated 7/30/14, indicated Resident #55 had identified problems related to unrealistic fears, delusions of family stealing his money and wanting to leave the facility. Approaches to the problem included, but were not limited to, "validate the issue that it would be upsetting, maintain a calm environment, offer resident to speak with daughter or redirect to another activity."</p> <p>During an interview on 9/25/14 at 10:00 a.m., the Memory Care Facilitator indicated Resident #55 had a behavior this morning. She indicated the resident had anxiety and fear related to family stealing from him. She indicated that he stated he needed to get home and had several clothing items packed and some pictures off the wall.</p>		<ul style="list-style-type: none"> ·Resident #55's behavior was documented into the tracking system. ·how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; ·All residents had the potential to have been affected by the alleged deficient practice. ·All residents who have exhibited maladaptive behavior on the Memory Care unit were reviewed by the Social Service team to ensure the care plan and behavior tracking system was applicable by October 10, 2014. ·All staff will be in-serviced on the facility ASC Behavior Management Policy & Procedure. Education will be provided by the Clinical Education Coordinator/Designee and completed by October 10, 2014. ·what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·All staff will notify the nurse on duty when a behavior occurs to ensure the tracking system reflects the behavior displayed and plan of care followed. ·Social Services will review the tracking system to ensure the documentation is accurate during IDT meeting. ·Social Service Department will receive one-on-one training by the Social Service Consultant/Designee on 				

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	<p>During review of the Event Report sheet for Resident #55, dated 9/25/14 at 9:45 a.m., the Memory Care Facilitator indicated the behavior occurred in his bed room at approximately 7:35 a.m. The report indicated the resident told the nurse people were stealing his belongings and he had to get to his motorcycle before something happened to it. Resident #55 had taken all of his clothes off the hangers and put them onto his bed and removed wall hangings. The intervention on the Event Report indicated Resident #55 was kept in an activity in the common dining room following the behavior.</p> <p>During review of the Behavior Administration report, from 9/21/14 through 9/25/14, the report indicated the resident had demonstrated no maladaptive behaviors for the days listed.</p> <p>During an interview on 9/26/14 at 10:37 a.m., the Director of Nursing (DoN) indicated the nurse on duty should have documented the behavior into the tracking system and the interventions that were used and if they were effective or not.</p> <p>Review of a current facility undated facility policy titled "ASC Behavior</p>		<p>the facility ASC Behavior Management Policy & Procedure by October 10, 2014.</p> <ul style="list-style-type: none"> · All staff will be in-serviced on the facility ASC Behavior Management Policy & Procedure. Education will be provided by the Clinical Education Coordinator/Designee and completed by October 10, 2014. how the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place; and · A CQI monitoring tool called Behavior Management CQI will be utilized every week x 4 and Monthly x 6. · Data will be collected by DNS/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed. · Non-Compliance with facility procedure may result in disciplinary action up to and including termination. by what date the systemic changes will be completed - October 10, 2014 				

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F000356 SS=C	<p>Management Policy & Procedure", which was provided by the Administrator on 9/26/14 at 1:10 p.m., indicated the following;</p> <p>" Policy: It is the policy of ...</p> <p>...Procedure:</p> <p>1. Care plans ...</p> <p>...4. When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records or signs off on the behavior on the monitoring form including what interventions were attempted during the episode and whether or not they were effective. "</p> <p>3.1-35(g)(1).</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses.</p>						

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	<p>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</p> <p>- Certified nurse aides.</p> <p>o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <p>o Clear and readable format.</p> <p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure posted nursing staff information was accurate and up to date for 1 of 5 days of the survey (9/22/14). This practice had the potential to affect 62 of 62 residents who resided in the facility.</p> <p>Findings include:</p> <p>During initial tour on 9/22/14 at 7:20 a.m., the nursing staff information was found to be posted with the date of 9/19/14.</p>	F000356	<p>F356 POSTED NURSE STAFFING INFORMATION It is the policy of this facility to post the following information on a daily basis; Facility Name, Current Date, Total Number and the Actual Hours Worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>·The Nurse Staffing Information was immediately changed to 9-22-14.</p> <p>how other residents having the</p>	10/10/2014

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	<p>During an interview on 9/22/14 at 7:55 a.m., CNA #1 indicated she was the person who made the schedule and was about to replace the old schedule with the updated schedule.</p> <p>During an interview on 9/25/14 at 9:54 a.m., the Administrator indicated she had assigned the 3rd shift person to update the staffing information. She indicated the weekend front desk person was responsible to post the information, but did not update the staff posting.</p>		<p>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 staff will be in-serviced on the facility Posted Nurse Staffing Information policy. Education will be provided by the Director of Nursing/Designee and completed by October 10, 2014. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; ·Third shift nursing staff will change the Posted Nurse Staffing Information at Midnight daily. ·Interdisciplinary team and the receptionist will ensure the posting and the accuracy of the posted nurse staffing information by conducting daily audits when applicable. 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; and ·A CQI monitoring tool called Posted Nursing Staffing Information CQI will be utilized daily x 1 month, every week x 4 and Monthly x 6. ·Data will be collected by DNS/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/26/2014
NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992		
(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>action plan will be developed.</p> <ul style="list-style-type: none"> ·Non-Compliance with facility procedure may result in disciplinary action up to and including termination. <p>by what date the systemic changes will be completed.</p> <p>-October 10, 2014</p>		