

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155810	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2014
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NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 18, 19, 20, 21, 22, and 23, 2014.</p> <p>Facility number: 000274 Provider number: 155810 AIM number: 100271660</p> <p>Survey team: Angela Selleck, RN TC Kim Davis, RN Jason Mench, RN Karen Koeberlein, RN</p> <p>Census Bed Type: SNF/NF: 86 Total: 86</p> <p>Census payor type: Medicare: 3 Medicaid: 83 Other: 0 Total: 86</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited.</p> <p>However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.</p> <p>Plan of Compliance is effective: June 16, 2014</p>	
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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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F000157 SS=D	<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 update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to ensure</p>	F000157	F 157 Notification of	06/16/2014			

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	<p>the physician was notified of a change in status of a resident's skin condition. This deficient practice affected 1 of 18 residents residing in the facility that were reviewed with physician orders. (Resident #60)</p> <p>Findings include:</p> <p>The clinical record for Resident #60 was reviewed on 5/20/14 at 9:56 a.m. Diagnoses included, but were not limited to, cerebral palsy, and seizure disorder. Resident #60 had a current diet order which indicated 100% of daily nourishment was provided by way of a g-tube (gastrostomy tube). Review of the BIMS (Brief Interview for Mental Status) indicated Resident #60 had severe cognitive impairment.</p> <p>Review of the most recent physician orders on 5/21/14, at 9:00 a.m. indicated Resident #60 had a current order in place to apply Calazyme (a cream to treat skin irritation) to Resident #60's g-tube site PRN (as needed) for redness and skin irritation. Resident #60 also had a current order in place, with a start date of 5/16/14, for antifungal cream to be applied to the bilateral axillary areas, (underarms) twice daily at 7:00 a.m., and 7:00 p.m., for excoriated skin (redness and irritation).</p>		<p>Changes</p> <p>Corrective action for residents identified:</p> <p>Resident #60 was reassessed and physician notified of change in skin condition.</p> <p>Identification of others at risk:</p> <p>Residents have been assessed and physician notified with any change in condition as indicated.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>The nursing staff were re-educated on change of condition and notification of physician. Residents will be reviewed during morning meeting, verbal report and</p>	

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	<p>Review of the most recent care plan, dated 1/30/14, indicated Resident #60 had a potential for alteration in skin status related to the g-tube feedings. An approach to the problem was to monitor Resident #60's g- tube site for signs and symptoms of infection and notify the physician as needed.</p> <p>During an observation on 5/21/14, at 8:21 a.m., Resident #60's abdominal g-tube site appeared extremely red and irritated. Upon closer observation, there did not appear to be any type of medication applied to the site. An observation at this same time of Resident #60's axillary areas, also found the skin to be extremely red and irritated. There also did not appear to be any type of medication applied to those areas. Additional observations on 5/22/14 at 8:25 a.m. and 5/23/14 at 9:00 a.m., also found Resident #60 to have redness and irritation around the g-tube site, without Calazyme applied, and a large area of redness and irritation in the axillary areas without antifungal cream applied.</p> <p>During review of the treatment administration record for Resident #60 on 5/23/14, at 9:00 a.m.,the calazyme cream had only been applied once between 5/18/14 and 5/23/14. The anti fungal</p>		<p>with 24 hour report to assist with ensuring notification of physician with change in condition.</p> <p>Monitoring of corrective action:</p> <p>The Director Of Nursing (DON) or designee will conduct a records audit on 5 residents, 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks to ensure all residents with significant changes in condition have been assessed and physician notified. The results of the audits will be reviewed during the morning managers meeting. These audits will be ongoing with the results reported and further recommendations given as indicated through the Quality Assurance Committee (QAC) monthly.</p>				

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	<p>cream had only been applied twice between 5/16/14 and 5/23/14.</p> <p>During review of Resident #60's recent progress notes, beginning from 5/16/14 to 5/23/14, no documentation of physician notification could be found in regard to the change in skin condition surrounding Resident #60's g-tube site.</p> <p>During an interview on 5/21/14, at 9:30 a.m., LPN #4 indicated Resident #60 had an order for Calazyme to be applied around the g-tube site as needed for redness and irritation. LPN #4 also indicated Resident #60 had a current order for anti-fungal cream to be applied to the axillary areas twice daily. LPN #4 indicated she had not completed the treatments. LPN #4 also indicated the physician had not been notified in regard to the redness and irritation around Resident #60's g- tube site.</p> <p>On 5/23/14, at 9:45 a.m., the Administrator indicated being unable to provide a policy in regards to physician notification or following physician orders.</p> <p>3.1-5(a)(3)</p>			

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

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on interview, observation and record review, the facility failed to offer evening banking hours for residents to access their personal funds. This affected 1 of 3 residents interviewed with a personal funds account and potentially affected 5 residents in the facility with a personal funds account. (Resident #83)</p> <p>Findings include:</p> <p>Resident #83 was interviewed on 5/19/14 at 1:46 p.m. regarding his ability to have access to his personal funds at the facility. Resident #83 indicated he was unable to withdraw money from his account on Friday, 5/16/14 at approximately 7:30 p.m. for a soda. Resident #83 stated "The nurse told me she did not see an envelope for me."</p> <p>During an interview with LPN #3 on 5/21/14 at 7:26 p.m., she indicated Resident #83 came to her on Friday evening 5/16/14 and wanted her to see if he had any funds available to him. LPN#3 indicated Resident #83 had no</p>	F000159	<p>F 159 Resident Funds</p> <p>Corrective action for residents identified:</p> <p>Resident # 83 can access his personal funds at the facility as needed.</p> <p>Identification of others at risk:</p> <p>All residents with a personal funds account had the potential to be affected. No other residents were identified.</p> <p>Measures to ensure this deficient practice does not</p>	06/16/2014

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	<p>funds in the petty cash box that night.</p> <p>During an observation of the after hours petty cash lock box with LPN#3 on 5/21/14 at 7:35 p.m., no petty cash envelope was observed for Resident #83. Two of the four resident envelopes for petty cash were empty, Residents #69 and 87. Resident #80's envelope had 25 cents and Resident #11's envelope had \$3.25 available.</p> <p>During an interview with the Business Manager on 5/22/14 at 8:47 a.m., she indicated that "the residents who are cognitively able to request money from their personal funds account are Resident #80, 87, 83, 69 and 11....An amount of 20 dollars for each resident is kept at the 200 hall nursing station in a locked cabinet and locked box for after business office hours. If residents need more than 20 dollars after hours, the resident needs to request it in advance."</p> <p>The Business Office Manager indicated all five residents had available at least 20 dollars in their accounts and should have money available to them after business hours.</p> <p>The Business Office Manager indicated the facility received a petty cash check once a week for resident petty cash. The</p>		<p>recur:</p> <p>A locked box will be kept at the 200 hall nurses station after business hours to ensure adequate monies are available to residents with personal funds at the facility 24 hrs/7 days a week.</p> <p>Monitoring of corrective action:</p> <p>Audits will be completed by the Business Office Manager (BOM) or designee 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks and then weekly for 4 weeks to ensure monies available in the locked box at the 200 nurses station. The results of the audits will be reviewed during the morning managers meeting. These audits will be ongoing with the results reported and further recommendations</p>	

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	<p>petty cash check had not been cashed and resulted in money not available after business hours for residents.</p> <p>The Business Office Manager stated "We had used all the petty cash. Money is refilled as needed and if the resident needs money then they would have to wait until the next business day or see the business office manager to receive money and would take money out of the facility if no petty cash is available."</p> <p>The "Resident Funds Petty Cash" Policy, dated 09/019/2013, provided by the Business Office Manager on 5/22/14 at 10:55 a.m., indicated:</p> <p>"...Purpose: To correctly maintain a petty cash fund.</p> <p>Procedure:</p> <p>...B. Disbursements of Resident Funds Petty Cash:</p> <p>...2a. Disbursements of Petty Cash will be limited to \$100.00 at one time. Requests for \$100 or less should be honored within the same day.</p> <p>...E. Petty Cash Reconciliation...</p> <p>...5. Reimbursements of Resident Funds</p>		<p>given as</p> <p>indicated through the monthly QAC meeting.</p>				

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F000250 SS=D	<p>Petty Cash will be processed on a priority basis in order to ensure residents have ready and reasonable access to funds...."</p> <p>3.1-6 (d) 3.1-6 (e) 3.1-6 (f)(1)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 observation, interview and record review, the facility failed to ensure behavior management was effective, interventions were updated and documented for 1 of 5 residents reviewed for behavior management. (Resident #75)</p> <p>Findings include:</p> <p>1. Resident #75's record was reviewed on 5/20/14 at 10:09 a.m. Current diagnoses include, but were not limited to, schizophrenia, major depressive disorder, diabetes, hypertension, obesity, acute bronchitis, leukopenia, history of seizures, dementia of Alzheimer's type with late onset with delusions, schizoaffective disorder (chronic condition with acute exacerbation),</p>	F000250	<p>F 250 SS-Medically Related Services</p> <p>Corrective action for affected resident: The Interdisciplinary team (IDT) assessed, reviewed and updated interventions to the care plan of resident #75.</p> <p>Identification of others at risk: No other residents identified. The IDT reviewed all behavior plans and updated as necessary.</p> <p>Measures to ensure this deficient practice does not recur: The IDT reviewed the care plan of resident #75 to ensure behavioral intervention strategies are included in the plan</p>	06/16/2014
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	<p>mental disability, depression and anxious mood.</p> <p>Review of physician order rewrites, dated 5/2014, indicated the resident was receiving Lexapro 10 milligrams tablet for depression and Invega Sustenna 156 milligrams injection intramuscular every 30 days for schizoaffective disorder.</p> <p>The "Behavior Tracking Record ", dated January through May 2014, was reviewed for Resident #75 on 5/20/14 at 2:30 p.m. It indicated the resident was monitored for the following behaviors cursing, resisting care, yelling out, physical aggression and undressing in public.</p> <p>The interventions for cursing included, "Calmly explained to her language wasn't approp. [appropriate], and asked if she was ok."</p> <p>The interventions for resisting care included "explain plans to give ahead of time, offer her at least two choices of time to give care, encourage her to participate in care as much as possible, if she still refuses, leave alone and reapproach after a few minutes, give verbal praise when resident performs her own care as much as possible."</p> <p>The interventions for yelling out included</p>		<p>and are relayed to staff on all shifts.</p> <p>Staff were re-educated on documenting effectiveness of interventions related to behavior management. Education included documenting and updating any new interventions implemented with behavior management on the Behavior Tracking form.</p> <p>Behaviors and effective interventions will be reviewed in the morning meeting.</p> <p>Monitoring of corrective action: Social Services will conduct audits on behavior management interventions for effectiveness and updating as resident condition warrants. The audits will be conducted on 5 residents, 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks. The results of the audits will be reviewed during the morning meeting. These audits will be ongoing with the results reported and further recommendations given as indicated through the Quality Assurance Committee (QAC) monthly.</p>	

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	<p>"remind me to use my door bell, offer me a truthful explanation of why you cannot help me right away, remind me that you will be with me as soon as you are done assisting the other resident or have your task completed and approach me in a soothing and non-judgmental manner."</p> <p>The interventions for physical aggression included "leave resident alone, talk calmly with resident, teaching and remove resident from other staff and residents.</p> <p>The interventions for undressing in public included, "immediately provide privacy (protect from public view), replace clothing, encourage to participate in redressing, check for personal needs, if/when unsuccessful maintain appropriate dress direct to private area to ensure privacy and encourage to participate in choice of two activities."</p> <p>Review of the "Behavior Tracking Record" for "Resist Care and Yelling Out" dated May 2014 indicated:</p> <p>On 5/5/14 yelling out "[The resident was] cry yelling Nurses was [were] trying [to]kill her." The behavior tracking record indicated the nurse tried to calm the resident down. No description of how the nurse tried to calm the resident</p>			

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	<p>down. No interventions under "Intervention Letter" and no documentation of effective or non-effective intervention.</p> <p>On 5/8/14 resisted care "[The resident] pulled [a] syringe from staff, [with the] needle exposed." No intervention documented and was documented as non-effective. No further interventions attempted.</p> <p>On 5/12/14 resisted care 8 a.m. to 1 p.m. "unknown" precipitating factors, 4 of 5 interventions attempted and listed as non-effective. No further interventions attempted.</p> <p>On 5/15/14, resisted care 7 a.m. to 1:30 p.m. "[While] attempting to apply [medication] patch [to resident, the resident resisted care]," 3 of 5 interventions attempted and non-effective. No further interventions attempted.</p> <p>On 5/17/14 resisted care 7 p.m. "[While] attempting to apply skin prep [a skin treatment to the resident, the resident resisted care]," 2 of 5 interventions attempted and non-effective. No further interventions attempted.</p> <p>Review of the "Behavior Tracking</p>			

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	<p>Record" for "physical aggression" dated April 2014 indicated:</p> <p>4/1/14 at 7:30 p.m. "[While] trying to give [the resident] meds/brtx [medications and a breathing treatment] and teaching [the] res [resident, the resident had a behavior of physical aggression]" 3 of 3 interventions attempted and non-effective. No further interventions listed.</p> <p>4/6/14 at 7 p.m. "[While] handing [the] res [resident a] med [medication] cup to take [her] meds [medications], the resident had a behavior of physical aggression. 2 of 3 interventions attempted and non-effective. No further interventions attempted.</p> <p>4/23/14 at 4:30 a.m. "[While checking the] a.m. b/s [blood sugar] and [attempting to administer the] insulin, [the resident had a behavior of physical aggression]" 3 of 3 interventions attempted and non-effective. No further interventions listed.</p> <p>During an interview with the Social Service Director on 5/20/14 at 2:42 p.m., she indicated the interventions for Resident #75's behaviors were not effective most of the time and the facility was not</p>				

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	<p>managing the resident's behaviors effectively.</p> <p>The Social Service Director indicated Resident #75 had an increase in behaviors since the decrease in Electroconvulsive Therapy (ECT). She indicated Resident #75 had received ECT weekly to start. ECT was now every 23 days.</p> <p>During an interview with the Social Service Director on 5/22/14 at 3:22 p.m., she indicated staff were not always documenting all behaviors and whether the interventions for the behaviors were effective or non-effective.</p> <p>The review of the "Behavior Assessment and Management" policy, dated 4/15/14, provided by the Social Service Director on 5/21/14 at 10:50 a.m., indicated:</p> <p>...Behaviors may be related to physical discomfort, overstimulation, unfamiliar surroundings, complicated tasks and frustrating interactions.</p> <p>1. Examine the behavior... ...2. Explore potential solutions... ...3. Try different responses...</p> <p>3.1-34(a) 3.1-34(a)(1)</p>						

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F000280 SS=D	<p>3.1-34(a)(2)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure a care plan was updated for 1 of 3 residents reviewed for rehabilitation, in a sample of 18 residents reviewed for care plans. (Resident #94)</p> <p>Findings included:</p> <p>Resident #94 was observed sitting in a wheelchair in the hallway interacting with staff. The Resident was not noted to</p>	F000280	<p>F 280 Care plans, revisions</p> <p>Corrective action for affected resident:</p> <p>Resident # 94's care plan was reviewed and updated based on resident status.</p> <p>Identification of others at</p>	06/16/2014			

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	<p>have a tracheostomy at this time.</p> <p>The clinical record of Resident #94 was reviewed on 5/20/14, at 10:30 a.m. The record indicated the Resident #94's diagnoses included, but were not limited to aphasia, anoxic brain encephalopathy, mental retardation and tracheostomy.</p> <p>The communication care plan for resident #94 indicated "The resident has difficulty understanding others due to MR diagnosis. He is unable to speak due to having a trach and Respiratory therapy is working on removal. Trach is capped during the day when respiratory therapist is here. Trach is planned for removal on 4/14/14."</p> <p>The clinical record indicated Residents tracheostomy was removed on 4/14/14. The care plan had not been updated to show this change.</p> <p>During an interview with the Minimum Data Set Assessment (MDS) Coordinator and Social Service Director on 5/20/14, at 1:30 p.m., the MDS Coordinator and Social Service Director indicated the care plan should have been updated after Resident #94's tracheostomy had been removed to show the current treatment plan.</p>		<p>risk:</p> <p>Residents care plans were reviewed by the IDT. Updates were made during review as indicated to reflect residents current status.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>Nursing staff and the IDT were educated on care plan revisions and following care plans for all residents. Care plans will be reviewed in the morning meeting to validate updates have been documented.</p> <p>Monitoring of corrective action:</p> <p>The MDS Coordinator, or designee will randomly select 5 charts to review for accuracy/revision of care 5 times a week for 1 month, weekly times 1 month and</p>	

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F000282 SS=E	<p>3.1-35(d)(2)(B)</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 observation, interview, and record review, the facility failed to ensure interventions identified in resident care plans were completed as ordered to prevent worsening skin conditions, provide assessments after a Mic-Key (feeding tube) was placed, provide repositioning of residents, and provide residents with a daily living routine. These deficient practices affected 4 of 10 residents who met the criteria in a sample of 18 residents reviewed for following care plans. (Resident's #60, #44, #34, and #76)</p> <p>Findings include:</p>	F000282	<p>then monthly thereafter.</p> <p>The audits will be ongoing with the results reported and further recommendations made through the Quality Assurance Committee monthly.</p> <p>F 282 Qualified Individuals Corrective action for affected resident: Resident # 60 had a head to toe skin assessment completed and treatment completed per physician order.</p> <p>Resident # 44 had an assessment completed regarding Mic Tube placement. No findings were noted.</p> <p>Resident # 76's Habilitation Plan (HAB) was</p>	06/16/2014			

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	<p>1. The clinical record for Resident #60 was reviewed on 5/20/14, at 9:56 a.m. Diagnoses included, but were not limited to, cerebral palsy, and seizure disorder. Resident #60 had a current diet order which indicated 100% of daily nourishment was provided by way of a g-tube (gastrostomy tube). Review of the BIMS (Brief Interview for Mental Status) indicated Resident #60 had severe cognitive impairment.</p> <p>During review of the most recent care plan, dated 1/30/14, it was indicated Resident #60 had a potential for alteration in skin status related to the g-tube feedings. An approach to the problem was to monitor Resident #60's g-tube site for signs and symptoms of infection and notify the physician as needed.</p> <p>Review of the most recent physician orders on 5/21/14 at 9:00 a.m. indicated Resident #60 had a current order in place to apply Calazyme (a cream to treat skin irritation) to the g-tube site PRN (as needed) for redness and skin irritation. Resident #60 also had a current order with a start date of 5/16/14, for antifungal cream to be applied to the bilateral axillary areas (underarms) twice daily at 7:00 a.m., and 7:00 p.m., for excoriated skin (redness and irritation).</p>		<p>assessed and updated to reflect current resident status.</p> <p>Resident # 34 had a head to toe skin assessment completed, care plan reviewed and updated based on current resident status.</p> <p>Identification of others at risk: Residents were assessed by the IDT to ensure services were provided based on care plan. No other residents were identified.</p> <p>Measures to ensure this deficient practice does not recur: Nursing staff and the IDT were re-educated on turning and repositioning residents and on following the resident's individual care plan.</p> <p>Monitoring of corrective action: The manager's will monitor/observe residents</p>	

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	<p>During an observation on 5/21/14, at 8:21 a.m., Resident #60's abdominal g-tube site appeared extremely red and irritated. Upon closer observation, there did not appear to be any type of medication applied to the site. An observation at this same time of Resident #60's axillary areas, also found the skin to be extremely red and irritated. There also did not appear to be any type of medication applied to those areas. Additional observations on 5/22/14 at 8:25 a.m. and 5/23/14 at 9:00 a.m., also found Resident #60 to have redness and irritation around the g-tube site, without Calazyme applied, and redness and irritation in the axillary areas without antifungal cream applied.</p> <p>During review of the treatment administration record for Resident #60 on 5/23/14 at 9:00 a.m., the Calazyme cream had only been applied once between 5/18/14 and 5/23/14. The anti fungal cream had only been applied twice between 5/16/14 and 5/23/14.</p> <p>During an interview on 5/21/14, at 9:30 a.m., LPN #4 indicated Resident #60 had an order for Calazyme to be applied to the g-tube site as needed for redness and irritation. LPN #4 also indicated Resident #60 had a current order for anti-fungal</p>		<p>to ensure the plan of care is being followed. An audit tool will be completed with the monitoring rounds 5 times a week for 1 month, weekly for 1 month and monthly thereafter.</p> <p>Audits will be ongoing with the results reported and further recommendations given as indicated through the Quality Assurance Committee monthly.</p>	

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	<p>cream to be applied to the axillary areas twice daily. LPN #4 indicated she had not completed the treatments.</p> <p>2. The clinical record of Resident #44 was reviewed on 5/22/14 at 9:00 a.m. The record indicated the resident's diagnoses included, but were not limited to Mental Retardation, Developmental Disability, Anoxic Brain Injury, Seizures, Respiratory Insufficiency, and Aphasia.</p> <p>The physician orders signed on 4/9/14 included an order, dated 12/11/13, for Vital 1.5 cal liquid, to run at 38cc(cubic centimeters) per hour via Mic -Tube (feeding tube) for a total of 14hrs (532 ml).</p> <p>A telephone order, dated 4/1/14, indicated the Mic-Tube was replaced on 4/10/14.</p> <p>The hospital's Discharge Instructions, dated 4/10/14, indicated, "Tube Placement at 10:26 a.m.."</p> <p>1- Rest today...</p> <p>4- Call surgeon for fever, persistent pain, excessive bleeding, nausea...</p> <p>8- Tylenol or Motrin for pain..."</p> <p>A nurse note, dated 4/10/14 at 6:00 a.m., indicated Resident #44 was taken to the hospital by ambulance for the Mic - Tube replacement.</p>				

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	<p>A nurse note, dated 4/10/14 at 1:30 p.m., indicated the resident returned from from the hospital. The note indicated only that the resident had no signs or symptoms of pain or distress.</p> <p>The next nurse note was dated 4/28/14.</p> <p>The April 2014 Vital Record included vital signs on 4/7/14.</p> <p>The Weekly Skin Assessments were completed on 4/8/14 and 4/15/14. There was no mention of the new Mic-Tube placement.</p> <p>The April 2014 Medication Administration Record included routine orders for blood pressure and pulse at 3:00 p.m. only.</p> <p>The April 2014 dietician review was completed on 4/8/14. The note indicated only that the resident's weight was stable.</p> <p>LPN #1 was interviewed on 5/22/14 at 10:15 a.m. During the interview, LPN #1 indicated there was no assessment of Resident #44 following the Mic-Tube placement on 4/10/14.</p> <p>3. The clinical record of Resident #76 was reviewed on 5/22/14 at 3:00 p.m.</p>			

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	<p>The record indicated the resident's diagnoses included, but were not limited to, Impulse Control Disorder, and Anxiety Disorder.</p> <p>The Care Plan, dated 7/20/13, indicated Resident #76 was unable to make safe decisions regarding life situations. The Care Plan interventions included a structured environment with a set routine for activities and Activities of Daily Living.</p> <p>The HAB Plan (Habilitation Plan) Goal, dated 9/9/13, indicated Resident #76 required an environment that provided a variety of social and leisure activities and social stimulation. The HAB Plan Objective and Task Analysis indicated the resident would attend a community day service program.</p> <p>A Social Service note, dated 5/5/14, indicated Resident #76 was provided with "... close ongoing supervision, structured activities, habilitation training and health monitoring by this facility... (Resident's name) works on habilitation goals related to ADLs [activities of daily living] and fine motor..."</p> <p>The facility's workshop schedule was provided by the Administrator on 5/19/14 at 9:00 a.m. The schedule indicated</p>			

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	<p>Resident #76 was scheduled for the community workshop one day a week.</p> <p>The door to Resident #76's room was observed closed on 5/18/14 from 2:30 p.m. until 5:30 p.m.</p> <p>On 5/19/14 at 8:30 a.m., 9:30 a.m., and 10:15 a.m. Resident #76 was observed in bed sleeping. Resident #76 was observed sitting on the floor outside the bedroom at 12:45 p.m. The resident remained in the hall until 2:45 p.m.</p> <p>On 5/20/14 at 8:00 a.m., Resident #76 was observed in the bed with the curtain closed. At 10:45 a.m., Resident #76 was observed in the doorway of the bedroom sitting on the floor.</p> <p>On 5/21/14 at 8:15 a.m., the door to Resident #76's bedroom was closed. At 11:00 a.m., the resident was sitting in a chair outside the bedroom. At 1:00 p.m., Resident #76 was ambulating in the hallway with a physical therapy assistant #5.</p> <p>4. The clinical record of Resident #34 was reviewed on 5/21/14 at 9:05 a.m. The record indicated the resident's diagnoses included, but were not limited to, Hypoxic Encephalopathy, severe dysphasia, reactive airway disease,</p>			

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	<p>contractures, Mental Retardation, and Seizures.</p> <p>The Episodic Care Plan, dated 5/11/14, indicated "Impaired skin integrity d/t [due to] loss of skin integrity as evidenced by: healed old wound, fragile skin R [right] back, partly open." The Episodic Care Plan Interventions included,"... Nurse to monitor for signs of infection at least daily. 2- Nurse to administer medication as directed. 3- Monitor resident's position at least every 2 hours to prevent adverse effects on skin related position. 4- Encourage fluid intake to promote hydration. 5- Nurse to document skin condition assessments and interventions implemented at least every shift. Nurse will notify physician and family with significant change."</p> <p>The Care Plan, dated 3/19/13, indicated "Potential for Alteration in Skin Integrity". The Care Plan Interventions included, "check my brief every two hours and change as needed and reposition me... Provide peri care [perineal care] with every incontinent episode..."</p> <p>On 5/19/14, Resident #34 was observed on his back, in the bed, at 9:00 a.m., 10:00 a.m., 11:00 a.m. and in his wheelchair at 12:10 p.m., 1:15 p.m. and</p>			

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	<p>2:30 p.m.</p> <p>On 5/20/14 Resident #34 was observed on his back, in the bed at 9:15 a.m., 10:30 a.m., 11:25 a.m., 1:15 p.m., and 2:15 p.m.</p> <p>On 5/21/14 Resident #34 was observed on his back in bed at 8:00 a.m., 9:00 a.m., and 10:00 a.m.</p> <p>On 5/21/14 at 10:30 a.m., the personal care of Resident #34 was observed. A yellow and brown stain was observed on the resident's bottom sheet and bed pad. CNA #6 was interviewed on 5/21/14 at 11:00 a.m. During the interview, the CNA indicated she had not checked on Resident #34 all shift, which began at 6:00 a.m. The CNA indicated she did not know when the third shift had changed the resident.</p> <p>On 5/21/14 at 11:00 a.m. 1:15 p.m., 3:00 p.m., and 3:30 p.m., Resident #34 was observed in the room in the wheelchair.</p> <p>On 5/21/14 at 7:30 p.m., Resident #34 was observed in bed. CNA # 7 was interviewed. During the interview, the CNA indicated Resident #34 was in the wheelchair at the beginning of her shift at 2:00 p.m. The CNA indicated she changed the resident's brief at 4:00 p.m.</p>						

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F000313 SS=D	<p>CNA # 6 was interviewed on 5/23/14 at 9:20 a.m. During the interview, the CNA indicated she did not know why Resident #76 only went out to workshop one day a week. The CNA indicated the resident enjoyed going.</p> <p>The Social Service Director (SSD) was interviewed on 5/23/14 at 10:00 a.m. During the interview, the SSD indicated Resident #76 used to go to the community based workshop five days a week. The SSD indicated she did not know why the resident went out only one day a week. The SSD indicated no changes were made to the resident's daily schedule to include a routine as the Care Plan and HAB plan indicated.</p> <p>3.1-35(g)</p> <p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p>			
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	<p>Based on observation, interview, and record review, the facility failed to ensure eye glasses were provided for 1 of 1 resident who met the criteria for vision review. (Resident #44)</p> <p>Findings include:</p> <p>Resident #44 was observed on 5/18/14 at 2:45 p.m. during the initial tour. Resident #44 was observed sitting in the bedroom, in the wheelchair. The resident was not wearing glasses.</p> <p>The clinical record of Resident #44 was reviewed on 5/22/14 at 9:00 a.m. The record indicated the resident's diagnoses included, but were not limited to, Mental Retardation, Developmental Disability, Anorexic Brain Injury, Seizures, Respiratory Insufficiency, and Aphasia.</p> <p>The last Optometrist visit was dated 3/22/13. The Optometrist note indicated the resident was to be referred to an eye specialist for cataract removal.</p> <p>The Quarterly Minimum Data Set (MDS) Assessment, dated 3/21/14, indicated Resident #44 required corrective lenses for impaired vision.</p> <p>The Care Plan, dated 3/21/14, indicated Resident #44 was visually impaired and</p>	F000313	<p>F 313 Vision and Hearing Treatment</p> <p>Corrective action for affected resident:</p> <p>Resident #44 was re-assessed by the IDT and care plan updated to reflect current status related to eye glasses.</p> <p>Identification of others at risk:</p> <p>Records reviewed and observations completed for all residents with vision impairment to ensure all prescription eye wear is available and worn by resident as indicated and resident will allow.</p> <p>Measures to ensure this deficient practice does not recur:</p>	06/16/2014

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	<p>"...I will wear my glasses so I can see..."</p> <p>LPN #1 was interviewed on 5/22/14 at 10:35 a.m. During the interview, the LPN indicated Resident #44 had glasses. The LPN indicated the glasses used to be kept in a drawer at the nurse station. The glasses were no longer in the drawer. LPN #1 indicated Resident #44 could not put on or remove her glasses alone.</p> <p>CNA #6 was interviewed on 5/22/14 at 12:45 p.m. During the interview, the CNA indicated Resident #44 was dependent on staff for care and the resident was not able to put on her own eye glasses. The CNA further indicated Resident #44 had not worn glasses for a long time. The CNA indicated she did not know what happened to the eye glasses.</p> <p>Resident #44's room was observed on 5/22/14 at 1:00 p.m. Two empty eye glass cases were observed in the resident's bedside table.</p> <p>The Social Service Director (SSD) was interviewed on 5/22/14 at 9:25 a.m. During the interview, the SSD indicated Resident #44 wouldn't keep glasses on and hadn't worn them for years.</p> <p>The ADoN (Assistant Director of</p>		<p>Staff were educated on following the residents plan of care regarding vision and assistive devices. Staff will ensure glasses are available to residents identified with need to wear glasses during routine resident rounds.</p> <p>Monitoring of corrective action: During rounds the managers will ensure all residents with prescription eye glasses are available and utilized as the resident will allow. Audits of resident eyeglasses will be conducted by Social Services Director (SSD), or designee, 5 times a week times 8 weeks, then monthly thereafter. The audits will be ongoing with the results reported and recommendations made as indicated through the Quality Assurance Committee monthly</p>				

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F000314 SS=G	<p>Nursing) was interviewed on 5/22/14 at 2:15 p.m. During the interview, the ADoN indicated the resident had an appointment scheduled for a cataract surgery consult. The ADoN indicated the consult had been put on hold due to transportation issues.</p> <p>3.1-39(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 provide turning and care for the prevention of pressure sores for 2 of 3 residents reviewed for pressure sores. This failure resulted in the development of pressure sores for the two residents. (Resident #34 and #55)</p> <p>Findings include:</p> <p>1. On 5/19/14, Resident #34 was</p>	F000314	<p>F 314 Prevention and Treatment of Pressure Ulcers Corrective action for affected resident: Residents #34 and #55 had a skin assessment, Braden Scale and care plan review completed and updated to reflect current resident status. Identification of others at risk: All residents were reviewed by the IDT and Braden Scale Assessments completed. Care plans were updated as indicated to reflect current resident status. Observation</p>	06/16/2014			

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	<p>observed on his back, in the bed, at 9:00 a.m., 10:00 a.m., 11:00 a.m. and in his wheelchair at 12:10 p.m., 1:15 p.m. and 2:30 p.m.</p> <p>On 5/20/14 Resident #34 was observed on his back, in the bed at 9:15 a.m., 10:30 a.m., 11:25 a.m., 1:15 p.m., and 2:15 p.m.</p> <p>On 5/21/14 Resident #34 was observed on his back in bed at 8:00 a.m., 9:00 a.m., and 10:00 a.m.</p> <p>On 5/21/14 at 10:30 a.m., the personal care of Resident #34 was observed. A yellow and brown stain was observed on the resident's bottom sheet and bed pad. CNA #6 was interviewed on 5/21/14 at 11:00 a.m. During the interview, the CNA indicated she had not checked on Resident #34 since all shift, which began at 6:00 a.m. The CNA indicated she did not know when the third shift had changed the resident.</p> <p>On 5/21/14 at 11:00 a.m. 1:15 p.m., 3:00 p.m., and 3:30 p.m., Resident #34 was observed in the room in the wheelchair.</p> <p>On 5/21/14 at 7:30 p.m., Resident #34 was observed in bed. CNA #7 was interviewed. During the interview, CNA #7 indicated Resident #34 was in the</p>		<p>rounds are completed to assist in implementation of care plan interventions. Measures to ensure this deficient practice does not recur: All residents care plans/medical records and observation rounds completed to ensure residents potentially at high risk for skin impairment had interventions in place based on plan of care. Staff were re-educated on turning and positioning and following plan of care. Licensed staff educated on validating interventions are in place during their shift.</p> <p>Monitoring of corrective action: The DON, or designee will complete resident observations (with focus on turning and repositioning) to validate interventions in place for residents identified to be at high risk for skin impairment. The observation audits will be completed 5 x's a week on all shifts for 4 weeks, 3 x's weekly on all shifts for 4 weeks, 1 x weekly for 4 weeks on all shifts and then monthly thereafter on all shifts.</p> <p>The audit results will be</p>				

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	<p>wheelchair at the beginning of her shift at 2:00 p.m. The CNA indicated she changed the resident's brief at 4:00 p.m.</p> <p>The clinical record of Resident #34 was reviewed on 5/21/14 at 9:05 a.m. The record indicated the resident's diagnoses included, but were not limited to, Hypoxic Encephalopathy, severe dysphasia, reactive airway disease, contractures, Mental Retardation, and Seizures.</p> <p>A telephone order, dated 5/11/14, indicated " Cleanse area on R [right] side of back with wound cleanser. Cover with Optifoam Gentle BID [two times a day] x 7 days then re-eval."</p> <p>A telephone order, dated 5/16/14, indicated "Cleanse R back with wound cleanser. Apply skin prep. Apply moisturized puracell AG [silver]. Cut to fit inside wound bed. Cover with Optifoam Gentle. Change Q [every] 3 days and PRN [as needed] X 7 days then re-eval."</p> <p>A nurse note, dated 5/19/14, at 11:00 p.m. indicated, "...Area to R back remains red, moist, no drng [drainage]. Surrounding skin P/W/D [pink/warm/dry]. No inflammation no foul odor, Area cleansed and TX applied</p>		<p>discussed in morning meeting and in the monthly QAC meeting for further recommendations.</p> <p>Observation audits will continue on all shifts for at least 6 months.</p>				

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	<p>per order. Tol [tolerated] well."</p> <p>The Braden Scale, an assessment to indicate a resident's risk to develop pressure ulcers was completed on 9/4/13, 11/25/13, 1/31/14, and 5/2/14. All assessment scores indicated Resident #34 was at high risk for the development of pressure sores.</p> <p>The Pressure Wound Flowsheet, dated 5/11/14, indicated a Stage Two pressure sore on the right side of Resident #34's back. The Flow sheet indicated the area measured 2.5 cm (centimeters) by 1 cm.</p> <p>The Episodic Care Plan, dated 5/11/14, indicated "Impaired skin integrity d/t [due to] loss of skin integrity as evidenced by: healed old wound, fragile skin R [right] back, partly open." The Episodic Care Plan Interventions included,"... Nurse to monitor for signs of infection at least daily. 2- Nurse to administer medication as directed. 3- Monitor resident's position at least every 2 hours to prevent adverse effects on skin related position. 4- Encourage fluid intake to promote hydration. 5- Nurse to document skin condition assessments and interventions implemented at least every shift. Nurse will notify physician and family with significant change."</p>			

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	<p>The Care Plan, dated 3/19/13, indicated "Potential for Alteration in Skin Integrity". The Care Plan Interventions included, "check my brief every two hours and change as needed and reposition me... Provide peri care [perineal care] with every incontinent episode..."</p> <p>2. On 5/19/14, Resident #55 attended the community based workshop all day, in his wheelchair.</p> <p>On 5/20/14 Resident #55 was observed on his back, in the bed at 9:05 a.m., 10:15 a.m., 11:20 a.m., 1:10 p.m., and 2:20 p.m.</p> <p>CNA # 7 was interviewed on 5/20/14 at 1:00 p.m. During the interview the CNA indicated two CNAs were scheduled to care for 25 residents. The CNA indicated she reported to work at 6:00 a.m., and started getting those residents up who were scheduled to go out to workshop. She had to stop to serve lunch, then get more residents up. The CNA indicated she did not take her own lunch. She indicated she did not have time to do anymore than get residents up as the Care Plan indicated.</p> <p>The clinical record of Resident #55 was reviewed on 5/20/14 at 3:45 p.m. The</p>			

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	<p>record indicated the resident's diagnoses included but were not limited to, Cerebral Palsy, seizure disorder, and Hypoxic Ischemic Encephalopathy.</p> <p>The Braden Scale, an assessment used by the facility to indicate the resident's risk for the development of pressure sores was completed on 9/27/13, 12/21/13 and 3/17/14. All three assessments indicated Resident #55 was at risk for the development of pressure sores.</p> <p>The Pressure Wound Flow Sheet, dated 4/4/14, a stage two pressure sore on the left side of the resident's back. The draining pressure ulcer measured 1.5 cm (centimeters) by 1.0 cm.</p> <p>A nurse note, dated 4/21/14 at 3:00 a.m., indicated "Area to L [left] back remains intact. Sm [small] bloody drg [drainage] noted. Cleansed and treatment applied."</p> <p>A nurse note, dated 4/25/14 at 3:00 a.m., indicated, "Area to back evaluated, two areas evolved into 1 area, 5 cm X 1.5 cm, New treatment orders."</p> <p>The Care Plan, dated 2/4/2010, indicated, " I am at risk for skin breakdown due to incontinence of bowel and bladder..." The Care Plan Interventions included: "1.</p>			

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F000329 SS=D	<p>Assess skin daily and document any abnormalities. 2. Check and change every two hours and prn [as needed]. 3. Turn and reposition every two hours when in bed..."</p> <p>The CNA assignment sheets indicated Resident #55 was dependent on staff for all care.</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 residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>			

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	<p>Based on interview and record review, the facility failed to ensure non pharmacological interventions were attempted prior to the administration of an psychoactive medication for 1 of 5 residents reviewed for the use of unnecessary medications. (Resident #80)</p> <p>Findings include:</p> <p>The clinical record of Resident #80 was reviewed on 5/20/14 at 1:45 p.m. The record indicated the resident's diagnoses included, but were not limited to, Cerebral Palsy, seizures, depression, spasticity, and aggressive behavior.</p> <p>A nurse note, dated 3/16/14 at 9:30 p.m., indicated "Resident extremely agitated, hitting, biting, scratching et [and] cursing at staff...Resident was assisted to bed and he crawled out six times... Notified Dr (doctor's name) et N/O [new order] received for Lorazepam (psychoactive) 0.5 mg [milligrams] PRN [as needed]. Resident has been sleeping since medication was administered...."</p> <p>The nurse note made no mention of any reason for the behavior, any precipitating factors for the behavior or of any nonpharmacological interventions attempted prior to the administration of the psychoactive medication.</p>	F000329	<p>F 329 Unnecessary Drugs</p> <p>Corrective action for affected resident:</p> <p>Resident #80 was re-assessed with no findings.</p> <p>Identification of others at risk:</p> <p>The DON and SSD reviewed records to identify residents not having non pharmacological interventions documented prior to administering prn psychoactive medications. No further residents were identified.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>Nurses were re-educated on using and documenting</p>	06/16/2014

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F000353 SS=E	<p>The Care Plan, dated 2/25/13, indicated "... I have behaviors of physical aggression, cussing, manipulation, and making false statements..." The Care Plan Interventions included: "diversional activities, encourage appropriate language, provide one on one time to cool down, and suggest other ways to express frustration."</p> <p>The next nurse note entry was dated 3/19/14, three days later. The note made no mention of a follow up to the administration of the medication.</p> <p>The Social Service Director (SSD) was interviewed on 5/20/14 at 3:20 p.m. During the interview the SSD indicated nonpharmacological interventions were not attempted by staff prior to the administration of the medication given on 3/16/14.</p> <p>3.1-48(a)(4)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable</p>		<p>non-pharmacological interventions before PRN psychoactive medications are administered.</p> <p>Monitoring of corrective action:</p> <p>The SSD, or designee, will conduct audits five times weekly times 4 weeks, weekly audits times 4 weeks, then monthly thereafter on documentation of non-pharmacological interventions prior to administering PRN psychoactive medication.</p> <p>The audit results will be discussed in morning meeting and in the monthly QAC meeting for further recommendations.</p>		

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	<p>physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an adequate amount of nursing staff was available to meet the needs of residents for 1 of 3 resident halls.</p> <p>Findings include:</p> <p>A CNA assignment sheet was provided by LPN # 1 on 5/19/14 at 9:10 a.m. It indicated the following: Two CNAs were scheduled to care for 25 residents on the 200 hall. Of these 25 residents, 17 required two members to transfer with a mechanical lift, one resident required three staff, and one resident was independent for transfers. 21 residents had feeding tubes to care for and 24 of the 25 residents were incontinent.</p>	F000353	<p>F 353 Sufficient 24 hour Nursing Staff</p> <p>Corrective action for affected resident:</p> <p>Resident #34 was re-assessed with no change in condition noted.</p> <p>Identification of others at risk:</p> <p>Based on resident observations and review of</p>	06/16/2014			

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	<p>The personal care of Resident #34 was observed with CNA #6 on 5/21/14 at 10:25 a.m. Upon entrance to the room, the resident was observed laying in bed. The bottom sheet, two bed pads, and air mattress were observed to be wet. A brown and yellow stain circled underneath the resident.</p> <p>CNA #6 was interviewed on 5/21/14 at 11:00 a.m. During the interview, CNA #6 indicated she had not been in the room to change or reposition the resident since she clocked in at 6:00 a.m. She indicated she did not know when the resident was last changed.</p> <p>The CNA indicated she came into work, started getting residents up for school and workshop. Then she stopped to feed breakfast, then got more residents up then stopped for the lunch assistance.</p> <p>CNA # 7 was interviewed on 5/21/14 at 7:45 p.m. During the interview, CNA #7 indicated she changed Resident #34 at 4:00 p.m. CNA #7 further indicated the first thing the second shift did when beginning work was to lay down all the residents living on the hall with feeding tubes. The CNA indicated the residents with feeding tubes all required two staff assistance for transfer. CNA #7 further</p>		<p>medical records no residents were identified to have significant change in condition.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>This facility has and will continue to ensure sufficient staffing. Licensed nurses will continue to assist in providing direct resident care and in turning and positioning as needed. Non licensed and non certified staff continue to assist nursing staff with tasks such as bed making, transportation of residents to activities, etc.</p> <p>The Executive Director and Director of Nursing review daily staffing and adjust based on needs of the resident.</p> <p>Team approach to providing</p>	

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NAME OF PROVIDER OR SUPPLIER VERNON MANOR CHILDRENS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1955 S VERNON ST WABASH, IN 46992
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	<p>indicated by the time that task was completed, residents who had been to the community workshop returned to the facility and all needed changed. Most of these residents required only one assist.</p> <p>Resident #34 was again observed on 5/22/14 at 8:30 a.m. The resident was in bed, on his back. Again, both bed pads and bottom sheet had a yellow, brown ring extending from the resident's mid back down to his thighs.</p> <p>On 5/22/14 at 10:15 a.m., CNA #6 was observed entering the resident's room to provide morning care.</p> <p>On 5/20/14 at 1:00 p.m., CNA #8 was interviewed. During the interview, CNA #8 indicated there were 2 CNAs for 200 hall rooms. The CNA indicated, they came in, did care, stopped for breakfast, did more care, and stopped for lunch. Residents didn't get bed checked or changed, sometimes until 2nd shift came in. Most days there are six CNAs working. Some days the nurses are assigned to do CNA work with residents but they didn't know what they were doing. CNA #8 indicated the nurses tried, but they weren't trained as CNAs. CNA #8 indicated they stayed until the work was done. Management told staff they couldn't have more help until the</p>		<p>care to the residents is focus with staff as well.</p> <p>Multiple recruitment and retention efforts are occurring and reviewed via the QAC process.</p> <p>Monitoring of corrective action:</p> <p>The Executive Director and Director of Nursing will review staffing daily to ensure sufficient staff is present to meet the needs of the residents.</p> <p>Staffing patterns and staffing needs will be reported to the Quality Assurance Committee for further review and recommendations monthly.</p>	

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F000356 SS=C	<p>census increased.</p> <p>Further information was requested regarding staffing on 5/23/14 at 10:30 a.m. during the QAA interview with the Administrator and Director of Nursing. No further information was presented.</p> <p>3.1-17(a)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <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> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available</p>			
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	<p>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 6 days of the survey (5/18/14). This practice had the potential to affect 86 of 86 residents residing in the facility.</p> <p>Findings include:</p> <p>During initial tour on 5/18/14, at 1:45 p.m., the posted nursing staff information was not found. The posted nurse staffing information was found at 3:30 p.m. at the 100 hall nursing station and was found to be posted with the incorrect date of 5/16/14.</p> <p>When LPN #2 was asked about the posted nursing staff information on 5/18/14 at 4:47 p.m., she indicated what was currently posted was all she had seen posted.</p> <p>On 5/18/14, at 4:53 p.m., the Assistant Director of Nursing (ADoN) posted nursing staff information for 5/17/14 and 5/18/14 and indicated that she had been</p>	F000356	<p>F 356 Staffing Hours Posted</p> <p>Corrective action for affected resident:</p> <p>No specific resident cited.</p> <p>Identification of others at risk:</p> <p>No residents affected.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>The scheduler will ensure daily staffing hours are posted and up to date at the 100 hall nurses station daily. The weekend manager will validate hours posted are accurate and up to date.</p>	06/16/2014

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F000441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to working on them. A policy regarding posting of nursing staff information was requested. No policy was provided.		The staff were educated on requirement to have staffing hours posted, accurate and up to date. Monitoring of corrective action: The Assistant Director Of Nursing, or weekend manager will conduct audits 5 times a week times 4 weeks, weekly audit times 4 weeks and then monthly thereafter, to ensure staffing hours are accurate and posted. The audit results will be discussed in morning meeting and in the monthly QAC meeting for further recommendations.	

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	<p>provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure handwashing and glove use were completed during the personal care for 1 of 2 residents and 1 of 2 CNAs observed providing direct care. (Resident #34)</p>	F000441	<p>F 441 Infection Control</p> <p>Corrective action for affected</p>	06/16/2014			

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	<p>(CNA # 6)</p> <p>Findings include:</p> <p>The personal care of Resident #34 was observed with CNA #6 on 5/21/14 at 10:25 a.m. Upon entrance to the room, the resident was observed laying in bed. The bottom sheet, two bed pads, and air mattress were observed to be wet. A brown and yellow stain circled under the resident. CNA #6 donned disposable gloves and removed the resident's brief and brief liner. A large amount of liquid brown stool was observed on the resident buttocks and in the brief.</p> <p>CNA #6 indicated the brief liner, brief, bed pads, sheet, and mattress were all wet. CNA #6 indicated "he's a wetter".</p> <p>Without changing gloves, CNA #6 washed the resident's penis with disposable wipes.</p> <p>Without changing her gloves, CNA #6 rolled the resident on his side, pulled more wipes from the plastic container and washed the resident's buttocks. A foam dressing was observed on the resident's buttocks.</p> <p>Without changing her gloves, CNA #6 pulled a clean brief and brief liner from</p>		<p>resident:</p> <p>Resident #34 was assessed with no signs or symptoms of infection noted.</p> <p>Identification of others at risk:</p> <p>Current residents were observed with no findings.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>All nursing staff was educated on infection control, specifically on hand hygiene, glove usage and hand washing procedures while providing care to residents.</p> <p>Return demonstrations were preformed with staff during various resident care procedures and work tasks, observing each step to ensure proper hand washing/hand</p>				

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	<p>the brief bag, and laid them on the wet bed beside the resident.</p> <p>CNA #6 changed her gloves, but did not wash her hands. CNA #6 put the liner inside the brief, and put them on the resident.</p> <p>While the resident continued to lay on the wet bed, CNA #6 put on the resident's socks, pants, and shirt.</p> <p>CNA #6 opened and pulled a mechanical lift sling from a roommate's closet.</p> <p>CNA #6 put the sling under the resident and with the assistance of LPN #1, used the mechanical lift to assist Resident #34 into the wheelchair. CNA #6 applied the resident's seatbelt connected to the wheelchair.</p> <p>Without washing her hands or changing her gloves, CNA #6 walked into the bathroom and pulled a toothbrush, toothpaste, toothette, and hair brush from plastic tote marked with the resident's name.</p> <p>Without washing her hands or changing gloves, CNA #6 applied toothpaste to the toothbrush and brushed the resident's teeth, rinsed his mouth with a détente, brushed the resident's hair, and washed</p>		<p>hygiene and glove usage. Staff was encouraged to ask questions during the return demonstrations to ensure that the policy was understood completely.</p> <p>Monitoring of corrective action:</p> <p>Managers, or designees will observe hand washing techniques and glove use while staff provide resident care on 5 staff per week, times 4 weeks, 3 staff per week times 4 weeks and monthly thereafter.</p> <p>The audit results will be discussed in morning meeting and in the monthly QAC meeting for further recommendations.</p>		

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	<p>the resident's face.</p> <p>Without washing her hands, removing or changing her gloves, CNA #6 pushed Resident #34's wheelchair into the hall, opened the shower room door, and disposed of the dirty brief and wipes which she put into a trash bag.</p> <p>CNA #6 removed her gloves and walked into another resident's room. CNA #6 was then reminded to wash her hands.</p> <p>CNA #6 was interviewed on 5/21/14 at 11:00 a.m. During the interview, the CNA indicated she had not checked on Resident #34 all shift, which began at 6:00 a.m. The CNA indicated she did not know when the third shift had changed the resident.</p> <p>2. During an interview with the Director of Nursing (DoN) regarding the facility's infection control program, the DoN indicated the last inservice and training records found were an inservice for handwashing on 4/8/13, with signatures of attendees, and a "Managers Daily Rounding" sheet showing an audit of assigned areas on 4/28/13. No further staff inservices for infection control could be found.</p> <p>3. A policy titled "INFECTION CONTROL", dated 1/22/12 and provided</p>			
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F009999	<p>by the DoN on 5/23/14 at 9:30 a.m., indicated;</p> <p>"Purpose: Provide a safe sanitary and comfortable living environment to help prevent development and transmission of infection..."</p> <p>"...4. Facility requires staff to perform hand hygiene after each direct resident contact..."</p> <p>3.1-18 (b)(4) 3.1-18 (l)</p> <p>3.1-18 INFECTION CONTROL PROGRAM</p> <p>...(b) The facility must establish an infection control program under which it does the following: ...(4) Provides orientation and in-service education on infection prevention and control, including universal precautions.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure staff were educated and inserviced on infection control procedures to prevent the spread</p>	F009999	<p>F 999 Infection Control Program</p> <p>Corrective action for affected resident:</p> <p>No specific resident cited.</p> <p>Identification of others at risk:</p> <p>Current residents observed with no findings.</p>	06/16/2014

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	<p>of infections. This had the potential to affect 86 of 86 residents who resided in the facility.</p> <p>Findings include:</p> <p>During an interview with the Director of Nursing (DoN) regarding the facility's infection control program, she indicated the last inservice and training records found were an inservice for handwashing on 4/8/13, with signatures of attendees, and a "Managers Daily Rounding" sheet showing an audit of assigned areas on 4/28/13. No further staff inservices for infection control could be found.</p> <p>3.1-18 (b)(4)</p>		<p>Measures to ensure this deficient practice does not recur:</p> <p>All nursing staff educated on infection control, specifically hand hygiene and hand washing procedures including return demonstration.</p> <p>Infection Control orientation and in-service will be conducted upon hire, annually and when identified via QA process/resident observations.</p> <p>Monitoring of corrective action:</p> <p>Infection Control audits to include hand washing and glove usage will be conducted by the DON, or designee, 5 times a week times 4 weeks, weekly times 4 weeks, then monthly.</p>		

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			The audit results will be reviewed at the morning meeting and monthly for follow up recommendations at the QAC meeting.		