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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155520 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>01/28/2015 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>BRAUN'S NURSING HOME | STREET ADDRESS, CITY, STATE, ZIP CODE<br>909 FIRST AVE<br>EVANSVILLE, IN 47710 |
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| F000000            | <p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey Dates: January 21, 22, 26, 27, 28, 2015.</p> <p>Facility Number 000437<br/>Provider Number 155520<br/>AIM Number 100273770</p> <p>Survey Team:<br/>Barbara Fowler, RN -TC<br/>Diana Perry, RN<br/>Denise Schwandner, RN<br/>Anna Villain, RN</p> <p>Census Bed Type:<br/>SNF/NF: 6<br/>NF: 45<br/>Total: 51</p> <p>Payor Type<br/>Medicare: 4<br/>Medicaid: 35<br/>Other: 12<br/>Total: 51</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2 - 3.1</p> <p>Quality review completed on February 3,</p> | F000000       |   |                      |

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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| F000225<br>SS=D    | <p>2015 by Jodi Meyer, RN</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must</p> |               |   |                      |

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|  | <p>be taken.</p> <p>Based on interview and record review, the facility failed to ensure prompt reporting of allegations of abuse to the State Survey Agency for 1 of 1 allegations of abuse investigations reviewed. (Resident #16)</p> <p>Findings include:</p> <p>On 1/21/15 at 2:18 p.m., Resident #16 indicated there had been an incident in which a staff member had jerked her out of bed and made her go to lunch. Resident #16 further indicated she felt the staff member had been abusive to her. Resident #16 indicated she had not told anyone and the surveyor could notify the Administrator.</p> <p>On 1/21/15 at 2:55 p.m., the Administrator was notified of Resident #16's allegation of abuse.</p> <p>On 1/26/15 at 11:00 a.m., the Administrator provided the state reportable's for the previous six months. The Administrator indicated there were only two, which were resident to resident abuse incidents.</p> <p>On 1/26/15 at 1:59 p.m., the Administrator and DON (Director of Nursing) were queried regarding the</p> | F000225   | <p>Plan of Correction Response for F225 Upon being informed of this alleged abuse, the Administrator and Director of Nursing <u>immediately</u> initiated an investigation into the complaint. The investigation consisted of speaking to the resident, interviewing other residents in proximity to the complainant and interviewing staff. Based upon the investigation, they were unable to substantiate the acquisition. The failure on the Administrators part to report the alleged abuse is not because of being unable to validate the complaint, but more from the source of the complaint. The Administrator wrongfully assumed that since an ISDH surveyor informed her of the resident's complaint, in theory the State had knowledge. This was corrected by reporting to the ISDH on January 26, 2015. The Administrator and Director of Nursing take allegations of abuse very seriously. They have and will continue to vigorously report, investigate and take appropriate action if applicable, of anyone accused of abuse. They will continue to provide for the resident's safety during any investigation by suspending the accused with pay. Additionally, they will continue the following practices:</p> <p>1. Require ALL staff to take a week vacation to promote healthy</p> | 02/27/2015   |  |   |  |

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|  | <p>reporting of Resident #16's allegation of abuse. The Administrator and DON indicated they had not reported the incident to the state because they were unable to substantiate the allegation.</p> <p>On 1/26/15 at 2:23 p.m., the Administrator and DON indicated the incident would be reported that date (1/26/15).</p> <p>On 1/28/15 at 8:50 a.m., the Administrator provided the "Preventing Abuse" policy, undated. The policy included but was not limited to, "All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies..."</p> <p>3.1-28(c)</p> |   | <p>rejuvenation.</p> <p>2.Offerrelaxation services periodically in the facility.</p> <p>3.Striveto have higher than required staffing levels to prevent stress and burnout.</p> <p>All personnel will be in-serviced regardingthe facilities "Abuse, Prohibition and Prevention Program". Beginning the week of February 23, 2015, either the Administrator and/or Director of Nursing will randomly interviewfive (5) residents for a time frame of four (4) weeks. Then five (5) random residents will be interviewed monthly for a period of three (3) months. On a quarterly basis according to the care conference schedule. Upon completion of the quarterly process, interviews willbe conducted randomly.</p> <p>Although the Director of Nursing is responsible forassuring that no form of abuse occur within the facility, the Administrator hasultimate responsibility for assurance and reporting immediately to the ISDH orappropriate agency. Since this facilityis a stand-alone facility, both theDirector of Nursing and Administrator will continue to hold each otherresponsible for compliance with F225 and 483.13(c) (1)(ii)-(iii), (c)(2) -(4). Any documentation regarding the POC for F225 will beavailable to the surveyors upon their request. Compliance Date: February 27, 2015 Margaret H. Braun, HFA</p> |                      |   |

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| F000226<br>SS=D  | <p>483.13(c)<br/>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br/>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br/>Based on interview and record review, the facility failed to ensure the abuse policy included the reporting of all alleged violations, in that, an allegation of abuse was not immediately reported to the State Survey Agency. (Resident #16)</p> <p>Findings include:</p> <p>On 1/21/15 at 2:18 p.m., Resident #16 indicated there had been an incident in which a staff member had jerked her out of bed and made her go to lunch.<br/>Resident #16 further indicated she felt the staff member had been abusive to her.<br/>Resident #16 indicated she had not told anyone and the surveyor could notify the Administrator.</p> <p>On 1/21/15 at 2:55 p.m., the Administrator was notified of Resident #16's allegation of abuse.</p> <p>On 1/26/15 at 1:59 p.m., the Administrator and DON (Director of</p> | F000226   | <p>Administrator Braun's Nursing Home</p> <p>Plan of Correction Response for F226 Upon being informed of this alleged abuse, the Administrator and Director of Nursing immediately initiated an investigation into the complaint. The investigation consisted of speaking to the resident, interviewing other residents in proximity to the complainant and interviewing staff. Based upon the investigation, they were unable to substantiate the acquisition. The failure on the Administrators part to report the alleged abuse is not because of being unable to validate the complaint, but more from the source of the complaint. The Administrator wrongfully assumed that since an ISDH surveyor informed her of the resident's complaint, in theory the State had knowledge. This was corrected by reporting to the ISDH on January 26, 2015. The Administrator and Director of Nursing take allegations of abuse very seriously. They have and will continue to vigorously report, investigate and take appropriate</p> | 02/27/2015   |  |   |  |

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|  | <p>Nursing) were queried regarding the reporting of Resident #16's allegation of abuse. The Administrator and DON indicated they had not reported the incident to the state because they were unable to substantiate the allegation. The Administrator and DON were notified at that time, all alleged violations of abuse are required to be immediately reported to the State Survey Agency.</p> <p>On 1/28/15 at 8:50 a.m., the Administrator provided the "Preventing Abuse" policy, undated. The policy included but was not limited to, "All suspected violations and all substantiated incidents of abuse will be immediately reported to appropriate state agencies..."</p> <p>3.1-28(a)</p> |   | <p>action if applicable, of anyone accused of abuse. They will continue to provide for the resident's safety during any investigation by suspending the accused with pay. Additionally, they will continue the following practices:</p> <ol style="list-style-type: none"> <li>1. Require ALL staff to take a week vacation to promote healthy rejuvenation.</li> <li>2. Offer relaxation services periodically in the facility.</li> <li>3. Strive to have higher than required staffing levels to prevent stress and burnout.</li> </ol> <p>All personnel will be in-service regarding the facilities "Abuse, Prohibition and Prevention Program". Beginning the week of February 23, 2015, either the Administrator and/or Director of Nursing will randomly interview five (5) residents for a time frame of four (4) weeks. Then five (5) random residents will be interviewed monthly for a period of three (3) months. On a quarterly basis according to the care conference schedule. Upon completion of the quarterly process, interviews will be conducted randomly. Although the Director of Nursing is responsible for assuring that no form of abuse occur within the facility, the Administrator has ultimate responsibility for assurance and reporting immediately to the ISDH or appropriate agency. Since this facility is a stand-alone facility,</p> |                      |   |

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| F000272<br>SS=D    | <p>483.20(b)(1)<br/>COMPREHENSIVE ASSESSMENTS<br/>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br/>                     Identification and demographic information;<br/>                     Customary routine;<br/>                     Cognitive patterns;<br/>                     Communication;<br/>                     Vision;<br/>                     Mood and behavior patterns;<br/>                     Psychosocial well-being;<br/>                     Physical functioning and structural problems;<br/>                     Continence;<br/>                     Disease diagnosis and health conditions;<br/>                     Dental and nutritional status;<br/>                     Skin conditions;<br/>                     Activity pursuit;<br/>                     Medications;<br/>                     Special treatments and procedures;<br/>                     Discharge potential;</p> |               | <p>both the Director of Nursing and Administrator will continue to hold each other responsible for compliance with F226 and 483.13(c). Any documentation regarding the POC for F226 will be available to the surveyors upon their request. Compliance Date: February 27, 2015<br/>                     Margaret H. Braun, HFA<br/>                     Administrator Braun's Nursing Home</p> |                      |

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|                    | <p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>Based on observation, interview, and record review, the facility failed to ensure accurate comprehensive assessments were completed for 1 of 34 Stage 2 residents reviewed, in that, diuretic medication was not recorded on the assessment. (Resident #34)</p> <p>Findings include:</p> <p>On 1/26/15 at 8:13 a.m., Resident #34's clinical record was reviewed. Resident #34 was admitted on 10/19/10. Resident #34's diagnoses included, but were not limited to, congestive heart failure.</p> <p>The most recent signed physician's recapitulation orders, signed 12/17/14, included, but were not limited to, Lasix (a diuretic medication) 40 mg (milligrams), one tablet, by mouth, daily, initiated on 10/19/10.</p> <p>The Significant Change MDS (Minimum Data Set) assessment, dated 10/28/14, indicated Resident #34 was not receiving any diuretic medications.</p> | F000272       | <p>Plan of Correction Response for F272</p> <p>An audit process will be implemented beginning the week of February 16, 2015. This process will consist of the following:</p> <ol style="list-style-type: none"> <li>1. Week two (2) schedule of the MDS calendar will be audited for accuracy. The calendar consists of 15 resident charts. All charts will be reviewed. Any input errors will be corrected and resubmitted.</li> <li>2. Starting with the week of February 23, 2015, a weekly audit of the MDS schedule will be audited for accuracy. The sample for this process will consist of 5% of the schedule. Any input errors will be corrected and resubmitted. This process will continue for 12 weeks.</li> <li>3. Upon completion of the weekly audit process, the same criteria outlined above will be implemented on a quarterly basis. Any input errors will be corrected and resubmitted.</li> <li>4. Upon completion of the quarterly audit process, the same criteria outlined above will be implemented on a random basis. Any input errors will be corrected and resubmitted.</li> </ol> | 02/27/2015           |

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| F000279<br>SS=D    | <p>On 1/26/15 at 10:34 a.m., Resident #34 was observed participating in activities.</p> <p>On 1/27/15 at 9:01 a.m., Resident #34 was observed propelling herself in the wheelchair in the hallway.</p> <p>On 1/28/15 at 8:41 a.m., the MDS Nurse was interviewed. The MDS Nurse indicated the use of the diuretic should have been assessed on the Significant Change MDS on 10/28/14.</p> <p>On 1/28/15 at 9:07 a.m., the MDS Nurse was interviewed. The MDS Nurse indicated the lack of the assessed diuretic use on the MDS assessment was an input error.</p> <p>3.1-31(a)</p> <p>483.20(d), 483.20(k)(1)<br/>DEVELOP COMPREHENSIVE CARE PLANS<br/>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</p> |               | <p>The Director of Nursing assumes responsibility for and ensures compliance. The Administrator is ultimately responsible for overall compliance.</p> <p>Any documentation regarding the POC for F272 will be available to the surveyors upon their request.<br/>Compliance Date: February 27, 2015</p> <p>Margaret H. Braun, HFA<br/>Administrator<br/>Braun's Nursing Home</p> |                      |

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|                    | <p>that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for 1 of 5 residents reviewed for unnecessary medications, in that, care plans were not developed for behaviors or side effects of psychoactive medications. (Resident #40)</p> <p>Findings include:</p> <p>On 1/26/14 at 10:36 a.m., Resident #40's clinical record was reviewed. Resident #40 was admitted on 7/1/11. Resident #40's diagnoses included, but were not limited to, depression with psychotic features and anxiety.</p> <p>The most recent signed physician's recapitulation orders, signed 1/22/15, included, but were not limited to:<br/>Wellbutrin (an anti-depressant medication) XL (extended release), 150 mg (milligram), one tab (tablet), po (by mouth), daily<br/>Pristiq (an anti-depressant medication), 50 mg, one tab, by mouth, daily</p> | F000279       | <p>Plan of Correction Response for F279</p> <p>All charts will be audited to assure that Care Plans are developed for behaviors and side effects of psychoactive medications. The charts will have accurate care plans by Friday, February 27, 2015. Appropriate staff will be in-serviced regarding the accuracy, timeliness and placement of care plans on the resident's chart. Upon completion of the full audit and assurance that all resident charts contain an accurate care plan, a full audit will be conducted monthly for 3 months, then a quarterly audit for six (6) months and then randomly thereafter. The implementation of a "Behavior/Intervention Monthly Flow Record" will be completed by Friday, February 27, 2015 for each psychotropic medication for every resident. This form will monitor any side effects of the medications and any behaviors. All licensed nursing personnel will be in-serviced by Friday, February</p> | 02/27/2015           |

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|                    | <p>Abilify (an anti-psychotic medication), 2 mg, one tab, by mouth, at bedtime<br/>Ativan (an anti-anxiety medication), 0.25 mg, po, at 1700 (5:00 p.m.)<br/>Ativan, 0.5 mg, po, at hs (bedtime)</p> <p>The care plans lacked a plan of care regarding behaviors or the monitoring for side effects of psychoactive medications.</p> <p>The Quarterly MDS (Minimum Data Set) assessment, dated 12/3/14, indicated Resident #40 received an anti-psychotic, anti-depressant, and anti-anxiety, 7 (seven) out of 7 days prior.</p> <p>On 1/26/15 at 11:14 a.m., LPN #3 indicated Resident #40 had behaviors in the past for suicidal ideation.</p> <p>On 1/27/15 at 9:06 a.m., Resident #40 was observed sitting in the hallway waiting for the beauty shop to open.</p> <p>On 1/27/15 at 3:51 p.m., the DON (Director of Nursing) was interviewed. The DON indicated behaviors and the monitoring of side effects of psychoactive medications should be included in the care plan. The DON further indicated she was unable to locate a plan of care regarding behaviors or the monitoring of side effects of psychoactive medications for Resident</p> |               | <p>27, 2015.</p> <p>The Director of Nursing assumes responsibility for and ensures compliance. The Administrator is ultimately responsible for overall compliance.</p> <p>Any documentation regarding the POC for F279 will be available to the surveyors upon their request.<br/>Compliance Date: February 27, 2015</p> <p>Margaret H. Braun, HFA<br/>Administrator<br/>Braun's Nursing Home</p> |                      |

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| F000280<br>SS=D  | <p>#40.</p> <p>On 1/28/15 at 2:00 p.m., the DON provided the "Behavior Assessment and Monitoring" policy, undated. The policy included, but was not limited to:<br/>"A Care Plan will be developed regarding behavior with non-pharmacological interventions."<br/>"The nursing staff and physician will monitor for side effects and complications related to psychoactive medications...."</p> <p>3.1-35(a)</p> <p>483.20(d)(3), 483.10(k)(2)<br/>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br/>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> |   |   |                      |   |

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|                    | <p>Based on observation, interview, and resident review, the facility failed to ensure the care plan was revised for 1 of 2 residents reviewed for falls, in a stage 2 sample of 34 residents. (Resident #53)</p> <p>Findings include:</p> <p>During an observation on 1/22/15 at 10:30 a.m., Resident #53 was observed to be lying in his bed with a floor mat alarm beside the bed. A chair alarm was observed to be in a wheelchair in the room.</p> <p>During an interview on 1/22/15 at 10:36 a.m., LPN #1 indicated Resident #53 had received a fall on 1/2/15. LPN #1 indicated the fall had been unwitnessed and the resident did not receive any injuries.</p> <p>The clinical record of Resident #53 was reviewed on 1/26/15 at 9:06 a.m. Resident #53 had diagnoses including, but not limited to, cerebral vascular accident with expressive aphasia, anxiety, psychosis related to post traumatic stress disorder, general debility, gait disturbance, dementia, hypertension, coronary artery disease, and osteoarthritis. A quarterly MDS (Minimum Data Set) assessment, dated</p> | F000280       | <p>Plan of Correction Response for F280</p> <p>All "fall" care plans will be reviewed for accuracy and updated with current interventions. This will be completed by Friday, February 27, 2015.</p> <p>Upon completion of the full audit and assurance that all resident charts are accurate, a full audit will be conducted monthly for 3 months, then a quarterly audit for six (6) month and then randomly thereafter.</p> <p>All licensed nursing staff will be in-serviced on the implementation of the "Post Fall Assessment" form. This will be completed by Friday, February 27, 2015.</p> <p>The "Post Fall Assessment" form will be submitted to the D.O.N. for review and compliance. The form will then be forwarded to the MDS Coordinator for care plan update. The Director of Nursing assumes responsibility for and ensures compliance. The Administrator is ultimately responsible for overall compliance.</p> <p>Any documentation regarding the POC for F280 will be available to the surveyors upon their request. Compliance Date: February 27, 2015</p> <p>Margaret H. Braun, HFA<br/>Administrator<br/>Braun's Nursing Home</p> | 02/27/2015           |

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|                    | <p>10/22/14, indicated Resident #53 had a BIMS (Brief Interview for Mental Status) score of 7 (seven) indicating severe cognitive impairment.</p> <p>Nurse's notes, dated 1/2/15 at 3:30 p.m., indicated the following: "Resident found on sitting on buttocks on floor. Resident had door closed attempting to transfer self from w/c (wheelchair) to bed."</p> <p>The resident had a care plan to address the potential for falls dated 4/15/14. The care plan indicated the call light was to be within easy reach of the resident. The care plan had not been updated since 7/14/14, when a bed/chair alarm and a floor alarm by the resident's bed was added.</p> <p>A "Post Fall Assessment" form, dated 1/2/15, indicated "resident teaching to leave door open and request help when transferring and staff teaching to offer rest time and lie resident down after lunch" was the immediate measure taken after finding the resident in the floor.</p> <p>During an interview on 1/26/15 at 9:49 a.m., LPN #1 indicated Resident #53 never used his call light. LPN #1 indicated the resident would not be able to retain any resident teachings.</p> |               |   |                      |

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| F000323<br>SS=E  | <p>During an interview on 1/28/15 at 11:10 a.m., the DON (Director of Nursing) indicated the MDS Coordinator is responsible for updating and revising the care plan.</p> <p>During an interview on 1/28/15 at 11:20 a.m., the MDS Coordinator indicated she is responsible for care plans revisions. The MDS Coordinator further indicated she did not know how the resident got into the floor, therefore, she did not have any new interventions to list on the care plan.</p> <p>A "Resident Incident Report," dated 1/2/15 and provided by the DON on 1/28/15 at 1:50 p.m., indicated the resident had received education against closing the door, the door was to be monitored and the resident checked on. The form further indicated the staff was educated to offer Resident #53 rest periods in the afternoon and to lay the resident down.</p> <p>The clinical record lacked any documentation of any revisions to the care plan.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25(h)<br/>FREE OF ACCIDENT</p> |   |   |  |  |   |  |

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|  | <p><b>HAZARDS/SUPERVISION/DEVICES</b><br/>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a safe environment for residents, in that, the bathroom water temperature in 8 of 8 resident's bathrooms were maintained at a safe temperature. (Room # 103, Room #104, Room #105, Room #106, Room #107, Room #108, Room #109, Room #110)</p> <p>Findings include:</p> <p>During observations of resident rooms, the temperatures of the bathroom sink water were as followed:</p> <ol style="list-style-type: none"> <li>On 1/21/15 at 2:44 p.m., the bathroom between Rooms #103 and Room #104 had a water temperature of 127 degrees Fahrenheit.</li> <li>On 1/21/145 at 11:55 a.m., the bathroom between Room #105 and Room #106 had a water temperature of 126 degrees Fahrenheit.</li> <li>On 1/21/15 at 11:39 a.m., the bathroom between Room #107 and Room</li> </ol> | F000323   | <p>Plan of Correction Response for F323</p> <p>Although the water temperature for Unit 100 was adjusted on January 21, 2015, the following protocol has been established to assure an adequate and safe water temperature is guaranteed.</p> <ol style="list-style-type: none"> <li>Beginning with Monday, February 9, 2015 the water temperature in all resident bathrooms and common shower rooms will be checked for safety. This process will occur Monday through Friday for a period of one (1) month.</li> <li>Starting with the week of March 9, 2015 the temperature for all areas listed above will be tested on Monday, Wednesday and Friday. This process will continue for a twelve (12) week period.</li> <li>Upon completion of the first (1st) quarterly process, the areas listed above will be tested on Monday and Friday. This process will continue for a twelve (12) week period.</li> <li>Upon completion of the second (2nd) quarterly process, the areas listed above will be checked every Monday. This schedule will continue indefinitely.</li> </ol> <p>All maintenance staff will be</p> | 02/27/2015           |   |

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|  | <p>#108 had a water temperature of 128.7 degrees Fahrenheit.</p> <p>4. On 1/21/15 at 1:17 p.m., the bathroom between Room #109 and Room #110 had a water temperature of 124.2 degrees Fahrenheit.</p> <p>5. Review of the bathrooms on 1/27/15 indicated the temperatures were between 114.2 and 118 degrees Fahrenheit.</p> <p>During an interview on 1/21/15 at 3:16 p.m., the Maintenance person indicated the facility had to replace the mixing valve on the water heater for the hall last week. He indicated another maintenance man was supposed to have rechecked the water the next day but he called in sick. He indicated when he checked the water temperatures approxiamately 10 minutes ago, the temperature had read 124 degrees Fahrenheit. The Maintenance person indicated he had turned the temperature down and would be rechecking the temperature in 30 (thirty) minutes. The Maintenance person indicated he checked 5 (five) rooms each month for the water temperatures. The Maintenance person provided a "Preventive Maintenance Schedule, dated 2014, which indicated the water temperatures for the 100 unit were between 116 -118 degrees Fahrenheit</p> |   | <p>in-serviced regarding proper water temperatures and observing existing preventative maintenance schedules.</p> <p>The Maintenance Supervisor assumes responsibility for and ensures compliance. The Administrator is ultimately responsible for overall compliance.</p> <p>Any documentation regarding the POC for F323 will be available to the surveyors upon their request.</p> <p>Compliance Date: February 27, 2015</p> <p>Margaret H. Braun, HFA<br/>Administrator<br/>Braun's Nursing Home</p> |  |  |   |  |

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| F000329<br>SS=D  | <p>during the month of December.</p> <p>During an interview on 1/21/15 on 3:57 p.m., the Maintenance person indicated he had rechecked the bathroom temperatures on the 100 unit and the temperatures were registering between 116 and 118 degrees Fahrenheit. The Maintenance person indicated the facility had forgot to recheck the temperatures after the mixing valve had been replaced.</p> <p>During an interview with the Maintenance person on 1/22/15 at 8:16 a.m., he indicated the temperatures on the south end of the 100 unit were registering 109 degrees Fahrenheit and the north end of the 100 unit were registering 110 degrees Fahrenheit this morning.</p> <p>3.1-19(r)(1)<br/>3.1-19(r)(2)</p> <p>483.25(l)<br/>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br/>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> |   |   |  |  |   |  |

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|                    | <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> <p>Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents reviewed for unnecessary medications, in that antianxiety, antidepressant, and mood stabilizers were administered without adequate monitoring. (Resident #9)</p> <p>Findings include:</p> <p>Resident #9 was observed on 1/21/14 at 1:20 p.m., sitting up in her wheel chair in her room with no behaviors noted.</p> <p>Resident #9 was observed on 1/27/15 at 10:15 a.m., in her wheel chair receiving a breathing treatment with no behaviors noted. She was dressed and waiting to get her hair done.</p> <p>The clinical record of Resident #9 was reviewed on 1/26/15 at 8:29 a.m.<br/>Diagnoses included, but were not limited</p> | F000329       | <p>Plan of Correction Response for F329</p> <p>The "Behavior/Intervention Monthly Flow Record" will be implemented in conjunction with F279. This document will remain in place while the resident is on psychotropic medication to monitor any behaviors or lack thereof. This form will be implemented by Friday, February 27, 2015</p> <p><u>All licensed nursing personnel and Social Services will be in-serviced by 2/27/2015.</u></p> <p>An audit of the "Behavior/Intervention Monthly Flow Record" will be reviewed weekly for one (1) month to assess for any behaviors or adverse side effects of medication. An audit will then be conducted monthly for 3 months and then quarterly with the care plan.</p> <p>Additionally, the "Request for Gradual Dose Reduction" will be modified to require the attending physician to be detailed as to why tapering cannot be attempted.</p> | 02/27/2015           |

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|                    | <p>to, Alzheimers disease, dementia, bipolar disorder, and mania.</p> <p>The most recent Quarterly MDS (minimum Data Self Assessment) dated 10/29/14 indicated Resident #9 experienced moderate cognitive impairment.</p> <p>A physician's order dated 1/24/11 indicated that Ativan (an antianxiety medication) 0.5 mg (milligram) po (by mouth) bid (twice daily) was to be started. An order dated 2/1/11 indicated that Depakote (a mood stabilizer) 125 mg 2 tabs (tablets) po tid (three times a day). An order dated 11/28/12 indicated that Celexa (an antidepressant) 10 mg po daily was to be started.</p> <p>There was no tracking of behaviors associated with antianxiety, antipsychotic, or antidepressant medication use found in the nurses notes or in the treatment record. There were also no dose reductions in these medications despite several recommendations from the pharmacists and nursing.</p> <p>An interview, on 1/27/15 at 2:29 p.m. with LPN #3, indicated the resident had a long history of psychotic behaviors in the past, but had not had any for a long time.</p> |               | <p>This will be implemented by Friday, February 27, 2015.</p> <p>The Director of Nursing assumes responsibility for and ensures compliance. The Administrator is ultimately responsible for overall compliance. Any documentation regarding the POC for F329 will be available to the surveyors upon their request. Compliance Date: February 27, 2015</p> <p>Margaret H. Braun, HFA<br/>Administrator<br/>Braun's Nursing Home</p> |                      |

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|                    | <p>LPN #3 further indicated that there had been several attempts made to get medication dose reductions and that the doctor had refused.</p> <p>An interview on 1/27/15 at 3:45 p.m. with the DON (Director of Nursing), indicated that Resident #9's behaviors were no longer tracked on a flow sheet due to the fact that she no longer had behaviors. She also indicated that she had spoken with the resident's physician several times regarding medication dose reductions and that he had refused.</p> <p>A policy titled Behavior Assessment and Monitoring was provided by the DON on 1/28/15 at 2:00 p.m. The policy indicated, "1. If a resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessments of changes (positive or negative) in the individual's behavior, mood, and function". It also indicated, "5. If psychoactive medications are used to treat behavioral symptoms of dementia, the nursing staff and Attending Physician will periodically reconsider their indication and consider whether they can be tapered or document why tapering cannot or should not be attempted (for example, recurrence of psychotic symptoms after several previous attempts</p> |               |   |                      |

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| F000465<br>SS=E  | <p>to taper medications).</p> <p>3.1-48(a)(3)</p> <p>483.70(h)<br/>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT<br/>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to provide a sanitary and comfortable environment for resident in 9 of 27 rooms observed in the stage 1 sample, in that, dirt and debris were observed in corners and edges of the bathroom floor, entry doors and closet doors were chipped, paint was chipped from a heating/cooling unit, and a wall was marred in a resident's room. (Room # 107, Room #108, Room #227, Room #312, Room #313, Room #314, Room #310, Room # 311, Room #308)</p> <p>Findings include:</p> <p>1. During an observation on 1/21/15 at 11:37 a.m., the bathroom sink between Room #107 and Room #108 was observed to be draining very slow and the hot water handle would turn 2 different ways. The same was observed on 1/21/15 at 2:27 p.m.</p> | F000465   | <p>Plan of Correction Response for F465</p> <p>1.Theplumbing for the bathroom sink between rooms 107 – 108 was removed andreplaced. This process was completed onFriday, February 13, 2015. The entirefaucet was replaced on Thursday, February 12, 2015.</p> <p>2.Theheating/cooling unit in room 108 was sanded and re-painted. The wall beside the entry door was repaintedas well. This was completed on Thursday,February 12, 2015. Materials have beenordered and an independent contractor has been engaged to laminate the entireentry door. This durable material willprevent further damage by wheelchairs, carts, etc. This will be completed by Friday, February27, 2015.</p> <p>3.Thebathroom floor in room 227, 308, 311, 312, and 314was scrubbed and cleaned onThursday, January 29, 2015. To assisthousekeeping personnel in maintaining a clean environment, hand held floorscrubbers will be ordered on</p> | 02/27/2015   |  |   |  |

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|  | <p>2. During an observation 1/21/15 at 11:36 a.m., Room #108 was observed to have paint chipped off of the heating/cooling unit, the wall beside the entry door was marred, and the entry door had chipped wood and was scraped. The same was observed on 1/27/14 at 2:27 p.m.</p> <p>3. During an observation on 1/21/15 at 2:40 p.m., Room #227 was observed to have dirt at the edges of the bathroom floor. The same was observed on 1/27/15 at 2:31 p.m.</p> <p>4. During an observation on 1/21/15 at 11:37 a.m., Room #312 was observed to have dirt and debris built up around the corners and edges of the bathroom floor. The same was observed on 1/27/15 at 3:36 p.m.</p> <p>5. During an observation on 1/21/15 at 11:32 a.m., Room #313 was observed to have wood chipped from the closet doors. The same was observed on 1/27/15 at 3:34 p.m.</p> <p>6. During an observation on 1/21/15 at 11:04 a.m., Room #314 was observed to have dirt and debris built up in the corners and edges of the bathroom floor. The bathroom and closet doors were chipped. The same were observed on 1/27/15 at 3:35 p.m.</p> |   | <p>Monday, February 16, 2015.</p> <p>4. Materials have been ordered and an independent contractor has been engaged to laminate the closet doors and drawers in room 308, 310, 313, and 314. This durable material will prevent further damage by tape, wheelchairs, etc. This will be completed by February 27, 2015.</p> <p>5. Materials have been ordered and an independent contractor has been engaged to laminate the bathroom doors in room 314. This durable material will prevent further damage by tape, wheelchairs, etc. This will be completed by February 27, 2015. All housekeeping staff were in-serviced regarding cleaning requirements, schedules and proper reporting of needed repairs on Friday, February 13, 2015. Beginning the week of February 23, 2015, the housekeeping supervisor will conduct a walk thru of the facility and identify any repairs and/or cleanliness issues. The supervisor will resolve any cleanliness issues immediately. The repair list will then be provided to the Administrator to assure compliance. This will be done weekly for one (1) month, then monthly for three (3) months, then quarterly for two (2) quarters and then randomly thereafter. The Maintenance Supervisor and housekeeping supervisor assumes responsibility</p> |  |  |   |  |

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|                    | <p>7. During an observation on 1/21/15 at 9:15 a.m., Room #310 was observed to have chipped wood form the closet doors. The same was observed on 1/27/15 at 3:35 p.m.</p> <p>8. During an observation on 1/21/15 at 2:11 p.m., Room #311 was observed to have dirt and debris built up in the corners and edges of the bathroom floor. The same was observed on 1/27/15 at 3:39 p.m.</p> <p>9. During an observation on 1/22/15 at 8:53 a.m., Room #308 was observed to have dirt and debris built up in the corners and edges of the bathroom floor, chipped paint around the entry door frame, and chipped wood from the closet door. On 1/27/15 at 3:40 p.m., Room #308 was observed to have dirt and debris built up in the corners and edges of the bathroom floor and chipped wood from the closet door.</p> <p>During an interview on 1/28/15 at 10:45 a.m., Housekeeper #1 indicated if something needed to be repaired, the person was to fill out a requisition and give it to the Administrator. Housekeeper #1 indicated the Administrator would give it to the proper person to take care of it. Housekeeper #1</p> |               | <p>for and ensures compliance. This will be assured by interrupting, enforcing and complying with a "Preventative Maintenance Schedule". The Administrator is ultimately responsible for overall compliance and will continue to assign weekly projects to housekeeping and maintenance staff. Any documentation regarding the POC for F465 will be available to the surveyors upon their request. Compliance Date: Overall Compliance February 27, 2015</p> <p>Margaret H. Braun, HFA<br/>Administrator<br/>Braun's Nursing Home</p> |                      |

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| F000514<br>SS=D    | <p>further indicated maintenance has been removing and resanding the doors when the wood is chipped on them.</p> <p>During an interview on 1/28/15 at 1:50 p.m., the Adm (Administrator) provided a deep cleaning schedule for the resident rooms and bathrooms. The schedule indicated resident bathrooms were to be deep cleaned monthly.</p> <p>3.1-19(f)</p> <p>483.75(l)(1)<br/>RES<br/>RECORDS-COMplete/ACCURATE/ACCE<br/>SSIBLE<br/>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure documentation was complete for 1 of 2 residents reviewed for accidents in a total sample of 30 who met the criteria, in that, documentation was lacking for a resident</p> | F000514       | <p>Plan of Correction Response for F514<br/>All licensed nursing staff will be in-serviced regarding newly written "Assessing Falls and Their Causes" Policy. This will be completed by Friday, February 27, 2015.</p> | 02/27/2015           |

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|                    | <p>with a fall. (Resident #53)</p> <p>Findings include:</p> <p>During an observation on 1/22/15 at 1:50 p.m., Resident #53 was observed to be lying in bed. A floor mat alarm was beside the bed and functioning.</p> <p>During an interview on 1/21/15 at 10:36 a.m., LPN #1 indicated Resident #53 had received a fall on 1/2/15. LPN #1 indicated the fall was unwitnessed and the resident was found sitting on the floor. LPN #1 indicated the resident had been trying to reach the door to request help with transferring to the bathroom and fell out of his wheelchair. LPN #1 indicated the resident did not receive any injuries.</p> <p>The clinical record of Resident #53 was reviewed on 1/26/15 at 9:06 a.m. Resident #53 had diagnoses including, but not limited to, cerebral vascular accident with expressive aphasia, dysphagia, anxiety, psychosis related to post traumatic stress disorder, general debility, gait disturbance, dementia, hypertension, coronary artery disease, and osteoarthritis. The quarterly MDS (Minimum Data Set) assessment, dated 10/22/14, indicated Resident #53 had severe cognitive impairment. The MDS</p> |               | <p>Additionally, all licensed nursing staff will be in-serviced on proper completion of the "Incident Report", "Post Fall Assessment" and documentation in the nurses' notes. This will be completed by Friday, February 27, 2015.</p> <p>The Director of Nursing will monitor any/and all changes in conditions to include an "Incident Reports", medication change and any new order as they occur. This included proper documentation in the nurses'. This will continue indefinitely.</p> <p>The Director of Nursing assumes responsibility for and ensures compliance. The Administrator is ultimately responsible for overall compliance. Any documentation regarding the POC for F514 will be available to the surveyors upon their request. Compliance Date: February 27, 2015</p> <p>Margaret H. Braun, HFA<br/>Administrator<br/>Braun's Nursing Home</p> |                      |

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|  | <p>assessment indicated Resident #53 was an extensive assist of 1 person for transfers and a extensive assist of 1 person for ambulation in the room. The MDS further indicated the resident was unsteady during transfers from the wheelchair to the bed and Resident #53 had upper and lower extremity impairment.</p> <p>A care plan, dated 4/14/14 and revised on 7/14/14, indicated Resident #53 had a potential for falls. The care plan indicated Resident #53 was to have a bed/chair alarm and a floor alarm by the bed.</p> <p>The clinical record lacked any documentation of the floor alarm or bed/chair alarm sounding when Resident #53 fell.</p> <p>During an interview on 1/28/15 at 8:45 a.m., the DON (Director of Nursing) indicated the documentation was lacking for the fall and it should have been documented whether the fall alarm was sounding.</p> <p>3.1-50(a)(2)</p> |   |   |                      |   |