

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00206249.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00207607.</p> <p>Complaint IN00206249 - Substantiated. Federal/State deficiencies related to the allegation are cited at F309.</p> <p>Survey dates: August 8, 9, 10, 11, 15, 16, and 17, 2016</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Census bed type: SNF/NF: 129 Total: 129</p> <p>Census payor type: Medicare: 14 Medicaid: 90 Other: 25 Total: 129</p> <p>Sample: 3</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	

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

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 34233 on August 23, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial</p>			

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	<p>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 interview and record review, the facility failed to notify the physician and family, related to a resident's refusal of dialysis treatment for 1 of 1 resident reviewed for physician/family notification. (Resident #115)</p> <p>Findings include:</p> <p>The clinical record for Resident #115 was reviewed on 8/11/16 at 2:03 p.m. Diagnosis included, but was not limited to, acute kidney failure.</p> <p>The nurses note, dated 6/16/16 at 8:26</p>	F 0157	<p>Issue: On 6/16/16 Resident #115 refused hemodialysis. The clinical record lacked documentation of physician and family notification of Resident #115 refusal of dialysis. The clinical record also lacked documentation of education provided to Resident #115 with regards to the risks of refusing dialysis.</p> <p>1. Plan of correction: (actions taken) 1. Physician and Family notification was completed and documented in the medical record. 2. Education was provided</p>	09/16/2016

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	<p>p.m., included, but was not limited to, the following: "...refused tx [treatment]..."</p> <p>The Hemodialysis Treatment record, dated 7/28/16 at 1:58 p.m., indicated Resident #115 did not have a Hemodialysis treatment on 6/16/16.</p> <p>During an interview on 8/11/16 at 3:38 p.m., RN (Registered Nurse) #16 indicated he notified the dialysis center of Resident #115's refusal, so the renal physician was aware. RN #16 indicated he did not notify Resident #115's primary care physician, but he notified the family when they came into the facility.</p> <p>The clinical record lacked documentation of physician and family notification of Resident #115's refusal of dialysis. The clinical record also lacked documentation of education provided to Resident #115 with regards to the risks of refusing dialysis.</p> <p>On 8/11/16 at 4:14 p.m., Corporate Nurse #16 provided a current copy of the document titled, "Notifications", dated 4/28/13. It included, but was not limited to, the following: "...Policy...Staff informs the patient, consults with their attending physician, and notifies the patient's surrogates when...A significant change occurs...Treatment needs to be</p>		<p>to the resident regarding the risks associated with refusing dialysis.</p> <p>3.A chart audit of the past 30 days was completed to identify areas of opportunity for notification in refusal of care and services and education of risks related. Any identified opportunity was immediately addressed with physician and family notification, education of risk related to refusal of care and services, and care plans were updated for non-compliance with care and services offered with choices and education of risk.</p> <p>2.Others at risk: All current residents have potential to be affected.</p> <p>1.A chart audit of the past 30 days was completed to identify residents refusing care and services.</p> <p>2.Audit identified areas of opportunity for notification in refusal of care and services and education of risks related. Any identified opportunity was immediately addressed with physician and family notification, education of risk related to refusal of care and services, and care plans were updated for non-compliance with care and services offered with choices</p>		

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	<p>altered...Rationale...Patients, families and/or responsible parties have the right to be notified of changes in the patient's physical, mental or psychosocial status, treatment plan...2. If the family has designated a member to receive calls, that individual is notified..."</p> <p>3.1-5(a)(2)(3)</p>		<p>and education of risk.</p> <p>3.Education: 1.SDC/designee will provide education to licensed nurses related to responsibilities of the licensed nurse when residents are refusing or noncompliant with care and services to include documentation of residents' choice, notification of the physician and responsible party, providing education of risk related to refusal, and updating the care plan.</p> <p>4.Ongoing audits/tools: 1.The DNS/designee will audit records 5 days per week for 4 weeks, then 4 days per week for 4 weeks, then 3 days per week for 4 weeks, then 2 days per week for 4 weeks to identify areas of opportunity for notification in refusal of care and services and education of risks related. Identified areas of opportunity will be corrected immediately. 2.The dashboard report will be reviewed with the IDT morning meeting as an ongoing process of this facility. 3.All findings will be acted upon immediately and results reviewed in the monthly PI meeting.</p>		

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F 0223 SS=G Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure abuse did not occur for 1 of 3 residents reviewed for abuse. (Resident #16)</p> <p>Findings include:</p> <p>The clinical record for Resident #16 was reviewed on 8/11/16 at 9:25 a.m. Diagnosis included, but was not limited to, dementia with behavioral disturbance. The MDS (Minimum Data Set) assessment, dated 6/3/16, indicated Resident #16 had a BIMS (Brief Interview of Mental Status) score of 4, which signified severely impaired cognition.</p> <p>The clinical record for Resident #99 was reviewed on 8/11/16 at 10:48 a.m. Diagnosis included, but was not limited to, Alzheimer's disease. The MDS</p>	F 0223	<p>5.The DNS is responsible for this compliance.</p> <p>Issue: On 7/14/16resident #16 held resident #99 down on bed and hit him in the face.</p> <p>1.Plan of correction: (actions taken) 1.Resident #16 is no longer a resident ofthis facility.</p> <p>2.Others at risk: All current residents havepotential to be affected. 1.A chart audit of the past 30 days wascompleted to identify residents' at risk for exhibiting challenging behaviors. 2.Any resident identified to have distressingbehaviors in the past 30 days will have a behavior assessment and IDT reviewcompleted to ensure appropriate interventions are developed to reduce and/oreliminate the cause of distressing behaviors</p>	09/16/2016			

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	<p>assessment, dated 7/29/16, indicated Resident #99 had a BIMS score of 5, which signified severely impaired cognition.</p> <p>The incident report, dated 7/14/16 at 15 p.m., included, but was not limited to, the following: "...Residents involved... [Resident # 16's name]...[Resident #99's name]...Brief Description of Incident...Staff heard resident in [Resident #99's room number] yelling for help...[Resident #16's initials] was found holding [Resident #99's initials] down leaning on his chest. [Resident #99's initials] was found to have a bruised eye...Type of Injury...[Resident #99's initials] sustained a purple bruise, swelling and small cut under...left eye...Immediate Action...The nurses separated the residents...[Resident #99's initials] was evaluated by the nurse...sent to [name of hospital] Emergency Department...Preventative Measures... [Resident #99's initials] was transported to [name of hospital] Emergency Department for evaluation and treatment...received a CT of the spine, face and head...A steri strip was placed on the laceration under the eye..."</p> <p>The typed witness statement, undated and untimed, included, but was not limited to, the following: "Resident...reported to me</p>		<p>including but not limited to ensuring the appropriate level of supervision is provided. Care sheets, behavior monitoring tools, and care plans will be updated immediately, as necessary.</p> <p>3. Residents and staff have been interviewed related to abuse. Any negative answer will be followed up immediately with appropriate action i.e. Allegation of abuse – removal of alleged abuser (if staff member immediate suspension), physical assessment and psychosocial assessment, reportable event, and launch investigation.</p> <p>3. Education:</p> <p>1. SDC/designee will provide education to staff related to responsibilities on Abuse, What Constitutes Abuse, Reporting Requirements, and intervention implementation for residents displaying challenging/distressing behaviors.</p> <p>2. SDC/designee will provide education to staff regarding completion and accuracy of the medical record; specifically, thorough assessment and documentation of challenging/distressing</p>	

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	<p>that on...way to room...witnessed [Resident #16's room number] standing in the doorway of [Resident #99's room number] asking...to let...outside. Resident...continued going to...room and a few minutes later when...came out of...room, ...witnessed [Resident #16's room number] holding [Resident #99's room number] down on the bed and hitting him in the face with...fist...[Social Services signature]..."</p> <p>The nurses note, dated 6/3/16 at 2:48 a.m., included, but was not limited to, the following: "...Res. [resident] started yelling out...roommate asked...to stop yelling, and the Res. [sic] became more belligerent asking...roommate to leave the room..."</p> <p>The nurses note, dated 6/3/16 at 6:51 p.m., included, but was not limited to, the following: "...Resident became very agitated tonight before supper walking into the glass door down 300 hall and yelling and cursing at the residents. The CNA [Certified Nursing Assistant] working the hall seen resident in another residents room and said resident had...can and was going to strike another resident...Resident has been tearful...with periods of yelling and cursing and verbal threatening..."</p>		<p>behaviors.</p> <p>1.Ongoing audits/tools: 1.The SSD/designee will audit behaviormonitoring records 5 days per week for 4 weeks, then 4 days per week for 4weeks, then 3 days per week for 4 weeks, then 2 days per week for 4 weeks to identify areas of opportunity and implement interventions to address causal factors including but not limited to the appropriate level of supervision. IDreview will be completed to ensure appropriate interventions were developed to reduceand/or eliminate the cause of distressing behaviors. Care sheets, behaviormonitoring tools, and care plans will be updated as necessary.</p> <p>2.The SSD/designee will review behaviormonitoring documentation monthly; residents will be reassessed quarterly,annually, with significant change, or more frequently, if deemed necessary, bythe interdisciplinary team to ensure appropriate interventions to reduce and/or eliminate the cause of distressing behaviors are updated, as necessary, as anongoing process of this facility.</p>				

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	<p>The nurses note, dated 6/7/16 at 10:59 a.m., included, but was not limited to, the following: "...Resident...wandering in others rooms and lying in other's beds..."</p> <p>The nurses note, dated 6/10/16 at 6:40 p.m., indicated Resident #16 continued to be tearful with periods of agitation.</p> <p>The physician's progress note, dated 6/14/16, included, but was not limited to, the following: "...[Resident #16's name]...Chief Complaint/Nature of Presenting Problem: Acute care visit per nursing request due to patient having increase in crying episodes and had a verbal altercation with another pt [patient]..."</p> <p>The nurses note, dated 6/16/16 at 2:18 p.m., included, but was not limited to, the following: "...Resident tearful with agitation this AM..."</p> <p>The nurses note, dated 6/17/16 at 2:19 p.m., indicated Resident #16 "was tearful and wandering frequently..."</p> <p>The nurses note, dated 6/19/16 at 6:54 p.m., 6/21/16 at 6:34 p.m., 6/23/16 at 3:02 p.m., and 6/24/16 at 3:39 p.m., included, but was not limited to, the following: "...Resident wandering in others rooms and around unit</p>		<p>3.The IDT will complete 40 Resident, Family,and Staff interviews every 6 month cycle as an ongoing process of this facilityin an effort to Identify, correct and intervene in situations in which abuse,neglect and/or misappropriation of resident property are more likely toooccur.</p> <p>4.The DNS/designee will review documentation5 days / week for 3 months to identify circumstances of potential abuse,immediately follow up with necessary steps, and education of staff.</p> <p>5.All findings will be reported to the EDimmediately and reported in monthly PI meeting. Abuse education and Resident Rights will continue to be provided in newemployee orientation and annually.</p> <p>2.The ED is responsible for this compliance.</p>				

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	<p>frequently..."</p> <p>The nurses note, dated 6/28/16 at 5:22 p.m., indicated Resident #16 was being discharged to a psychiatric hospital.</p> <p>The nurses note, dated 6/30/16 at 2:20 p.m., included, but was not limited to, the following: "...Received call for [name of psychiatric hospital] with update on resident. States [Resident #16's first name] has been combative and verbally aggressive with staff and peers. Has been in a physical altercations with another peer..."</p> <p>The nurses note, dated 7/12/16 at 12:39 a.m., indicated Resident #16 was readmitted to the facility from the psychiatric hospital.</p> <p>The behavior note, dated 7/12/16 at 9:22 p.m., included, but was not limited to, the following: "...Resident refusing to go to bed, wandering into other residents [sic] rooms, being verbal [sic] aggressive to others, [sic] tried to hit this nurse and cna [sic] with cane, [sic] assisted to lounge area but refuses to sit down, yelling out and cursing loudly upsetting other residents. Also beating on 200hall [sic] exit doors causing alarm to go off, [sic] was assisted away from doors per other male nurse but continued to be</p>			

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	<p>aggressive..."</p> <p>The behavior note, dated 7/14/16 at 1:52 p.m., included, but was not limited to, the following: "...[Resident #99's room number] was yelling, "Help" from room. This nurse and nurse 2 entered room and noted resident [Resident #16] on top of [Resident #99's room number] with both arms across [Resident #99's room number] neck. [Resident #99's room number] head was turned to the left and pressed into the mattress. Resident [Resident #16] appeared to be choking [Resident #99's room number]..."</p> <p>The physicians progress note, dated 7/14/16, included, but was not limited to, the following: "...[Resident #16's name]...Chief Complaint/Nature of Presenting Problem: Acute visit for readmission post hospital stay...History of Present Illness: Pt [patient] also just had an altercation with another resident in which staff found him on top of the other resident attempting to choke him. It is now known what provoked him, if anything..."</p> <p>During an interview on 8/15/16 at 1:07 p.m., LPN (Licensed Practical Nurse) #19 indicated she was working on the day of the incident and responded to Resident #99's call for help. LPN #19 indicated</p>			

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F 0272 SS=D Bldg. 00	<p>Resident #16 was laying on top of Resident #99 with his forearm across Resident #99's neck. LPN #19 also indicated Resident #16 wandered a lot. LPN #19 further indicated it appeared Resident #16 was choking Resident #99.</p> <p>On 8/11/16 at 11:14 a.m., the Administrator provided a current document titled, "Abuse", dated 7/28/14. It included, but was not limited to, the following: "...Policy...Verbal...physical...abuse...are strictly prohibited...Rationale: Patients have the right to be free of verbal...physical...abuse...Definitions...Abuse...The willful infliction of injury...with resulting physical harm...Verbal Abuse...The use of oral...or gestured language that willfully includes disparaging and derogatory terms to residents...or with their hearing distance regardless of their age, ability to comprehend, or disability..."</p> <p>3.1-27(a)(1) 3.1-27(b)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p>			

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	<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: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure comprehensive assessments were completed accurately related to weights, oral exams and medications for 3 of 26 residents reviewed for comprehensive MDS (Minimum Data Set) assessments. (Resident #9, #147, and #108)</p> <p>Findings include:</p>	F 0272	<p>Issue: MDS coding inaccuracy/incomplete for sections K Swallowing/Nutritional Status (Resident#108), L Oral/Dental Status (Resident #9), and N Medications (Resident #147)</p> <p>1. Plan of correction: (actions taken) 1. Resident #108 is no longer a resident of this facility. 2. Resident #9</p>	09/16/2016

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
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	<p>1. The clinical record for Resident #108 was reviewed on 08/11/2016 at 9:08 A.M. The resident was admitted on 05/18/2016 and discharged on 06/19/2016.</p> <p>Diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, sequela, cerebellar stroke syndrome, acute respiratory failure, chronic obstructive pulmonary disease, and alcohol dependence. The comprehensive Admission MDS assessment, dated 05/24/2016, did not have a weight listed and the 14-day, 30-day, and discharge assessments did not have weights listed. The admission assessment further indicated Resident #108 had received nothing by mouth, received tube feedings, and was cognitively impaired with a BIMS (Brief Interview for Mental Status) score of 4.</p> <p>During an interview on 08/11/2016 at 11:08 A.M., MDS Coordinator #6 indicated a newly admitted resident should have been weighed within 24 hours after admission.</p> <p>During an interview on 08/11/2016 at 11:26 A.M., MDS Coordinator #7 indicated she does not personally go out and get the residents' weights. She</p>		<p>modifications to section L on 6/6/2016 MDS assessment were completed</p> <p>3.Residents #147 modifications to section N on 5/5/2016, 5/17/2016, and 6/8/2016 MDS assessment were completed</p> <p>2.Others at risk: All current residents have potential to be affected.</p> <p>1.A review of the past 3 months MDS coding for sections K Swallowing/Nutritional Status, L Oral/Dental Status, and N Medications was completed for all current residents to identify coding opportunities.</p> <p>2.Any coding opportunity identified by review was immediately corrected and modified assessment submitted.</p> <p>3.Education:</p> <p>1.DDCM/designee will provide education to MDS coordinators, Registered Dietician, Social Service Department Employees, and Director of Nursing on MDS coding for sections K Swallowing/Nutritional Status, L Oral/Dental Status, and N Medications.</p> <p>4.Ongoing audits/tools:</p> <p>1.The DDCM/designee will</p>				

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	<p>further indicated if she saw that someone did not have a weight posted when she was doing the MDS assessment, she would find someone to help her get the weight.</p> <p>During an interview on 08/11/2016 at 2:22 P.M., the RD (Registered Dietician) indicated the resident should have had weekly weights for the first 4 weeks following admission. The RD further indicated weights were not documented for Resident #108.</p> <p>During an interview on 08/11/2016 at 4:28 P.M., the DON (Director of Nursing) indicated the facility had the dietician routinely check the resident to ensure the health was maintained for residents who received tube feedings. The dietician would monitor the resident's weights and labs. The DON further indicated weights are checked when there was a change in the amount of tube feeding, if the resident develops a wound, or if there were abnormal labs. She also indicated weights are at least checked monthly when residents are admitted.</p> <p>The Evaluation and Documentation of a New Admission/Re-admission of a Patient policy was provided by District Director of Clinical Operations on</p>		<p>audit MDS coding for sections K Swallowing/Nutritional Status, L Oral/Dental Status, and N Medications prior to submission for 90 days then monthly through Resident Level review as an ongoing practice. Identified areas of opportunity will be corrected immediately.</p> <p>2. All findings will be acted upon immediately and results reviewed in the monthly PI meeting.</p> <p>5. The DNS is responsible for this compliance.</p>				

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	<p>08/11/2016 at 12:08 P.M. and reviewed at that time. The policy indicated, "...The regulations also require that a facility conduct a comprehensive assessment of a patient within 14 calendar days after admission...Measure the patient's height and weigh the patient using an appropriate scale to establish a baseline for monitoring nutritional status and for calculating medication dosages."</p> <p>2. During an observation on 08/09/2016 at 2:38 P.M., Resident #9 had several missing teeth as well as several teeth with dark and pitted areas.</p> <p>Record review for Resident #9 was completed on 08/11/2016 at 2:58 P.M. The Significant Change MDS assessment, dated 06/06/2016, indicated the resident had a BIMS of 14, which meant the resident was cognitively alert and oriented. The MDS further indicated the resident had no current dental concerns.</p> <p>Resident #9's current care plan was provided by the DDCO (District Director of Clinical Operations) on 08/16/2016 at 3:25 P.M. and was reviewed at that time. The care plan indicated Resident #9 had "obvious caries in teeth."</p> <p>Resident #9's "Medical Nutrition Therapy</p>			

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	<p>Assessment", dated 06/06/2016, indicated the resident had caries/decay and missing teeth.</p> <p>Resident #9's "Patient Nursing Evaluation", dated 03/08/2016, indicated the resident had caries/decay.</p> <p>During an interview on 08/15/2016 at 4:38 P.M., MDS Coordinator #7 indicated because Resident #9's most recent oral exam had incorrectly indicated the resident had no dental concerns, she had incorrectly coded the resident as having no dental concerns on the MDS. MDS Coordinator #7 further indicated she did look in the resident's mouth and she could not say whether or not the resident's teeth showed decay/caries.</p> <p>During an interview on 08/16/2016 at 2:35 P.M., the DON (Director of Nursing) indicated nurses, including the MDS Coordinator, are qualified to do an oral exam, including indicating when a resident had tooth decay.</p> <p>The current facility policy, titled "CMS's RAI Version 3.0 Manual" and dated October, 2015, was provided by Corporate Nurse #22 on 08/11/2016 at 4:17 P.M. and was reviewed at that time. The policy indicated, "...Cavity A tooth</p>			

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	<p>with a discolored hole or area of decay that may have debris in it...Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions...Conduct exam of the resident's lips and oral cavity..."</p> <p>3. Record review for Resident #147 was completed on 08/11/2016 at 8:29 A.M. The Resident's diagnoses included, but were not limited to, anxiety, bipolar disorder, and insomnia. The Significant Change MDS assessment, dated 05/05/2016, indicated the resident had a BIMS (Brief Interview for Mental Status) of 08, which meant the resident had cognitive impairment. The MDS indicated Resident #147 received hypnotic medication seven of the seven days during the look back period.</p> <p>Resident #147's MAR (medication administration record) indicated the resident had been receiving Trazodone HCl (hydrochloride), an antidepressant, for insomnia.</p> <p>During an interview on 08/16/2016 at 8:28 A.M., MDS Coordinator #6 indicated Resident #147's Trazodone had been coded as a hypnotic but should not have been.</p> <p>The current facility policy, titled "Patient</p>			

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F 0278 SS=D Bldg. 00	<p>Assessment" and dated 05/13/2016, was provided by the DDCO (District Director of Clinical Operations) on 08/16/2016 at 2:57 P.M. and was reviewed at that time. The policy indicated, "...Appropriate, qualified health professionals correctly document the patient's medical, functional, and psychosocial problems..."</p> <p>3.1-31(d)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to</p>			

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	<p>certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the Quarterly MDS (Minimum Data Set) assessment accurately reflected a resident's clinical condition related to pressure risk for 1 of 26 residents reviewed for MDS assessments. (Resident #30)</p> <p>Findings include:</p> <p>Record review for Resident #30 was completed on 08/11/2016 at 9:55 A.M. The resident's Quarterly MDS assessment, dated 07/05/2016, indicated the resident had a BIMS (Brief Interview for Mental Status) of 99, which meant the interview was not completed. The resident's diagnoses included, but were not limited to, hypertension, dementia, and hemiplegia or hemiparesis. The MDS assessment also indicated the resident did not have a pressure ulcer and was not at risk for a pressure ulcer.</p> <p>Resident #30's "Braden Scale for Predicting Pressure Sore Risk Original", dated 06/06/2016, indicated the resident had a score of 14 and was a moderate risk</p>	F 0278	<p>Issue: MDS codinginaccuracy/incomplete for sections M Skin Conditions (Resident #30)</p> <p>1.Plan of correction: (actions taken)</p> <p>1.Resident #30 modifications to section M on7/5/2016 MDS assessment were completed</p> <p>2.Others at risk: All current residents havepotential to be affected.</p> <p>1.A review of the past 3 months MDS codingfor section M Skin Conditions was completed for all current residents toidentify coding opportunities.</p> <p>2.Any coding opportunity identified by thereview was immediately corrected and modified assessment submitted.</p> <p>3.Education:</p> <p>1.DDCM/designee will provide education to MDScoordinators and Director of Nursing on MDS coding for section M SkinConditions.</p>	09/16/2016

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F 0282 SS=D Bldg. 00	<p>for developing a pressure ulcer.</p> <p>Resident #30's current care plan indicated the resident had a potential for skin/tissue integrity impairment. The resident's goal was to not develop further pressure areas.</p> <p>During an interview on 08/16/2016 at 8:32 A.M., MDS Coordinator #6 indicated the pressure risk documentation on the MDS assessment would come from the resident's most recent Braden score. She further indicated Resident #30's MDS was coded incorrectly.</p> <p>The current facility policy, titled "Patient Assessment" and dated 05/13/2003, was provided by the DDCO (District Director of Clinical Operations) on 08/16/16 at 2:57 P.M. and was reviewed at that time. The policy indicated, "...A comprehensive, accurate, standardized, reproducible assessment of each patient's functional capacity and needs is conducted using the Resident Assessment Instrument (RAI)..."</p> <p>3.1-31(d)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p>		<p>4.Ongoing audits/tools:</p> <p>1.The DDCM/designee will audit MDS coding for section M Skin Condition prior to submission for 90 days then monthly through Resident Level Review as an ongoing practice. Identified areas of opportunity will be corrected immediately.</p> <p>2.All findings will be acted upon immediately and results reviewed in the monthly PI meeting.</p> <p>5.The DNS is responsible for this compliance.</p>		

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure resident care plans were followed related to obtaining weights for 2 of 26 residents reviewed for care plans. (Resident #64 and #108)</p> <p>Findings include:</p> <p>1. Record review for Resident #64 was completed on 08/11/2016 at 11:19 A.M. The resident's MDS assessment, dated 07/07/2016, indicated the resident had a BIMS (Brief Interview for Mental Status) of 07, which meant the resident was cognitively impaired. The resident's diagnoses included, but were not limited to, multiple sclerosis and anxiety.</p> <p>Resident #64's clinical record showed no weights recorded from 05/10/2016 to 07/29/2016.</p> <p>Resident #64's current care plan indicated Resident #64 was at risk for nutritional decline the interventions included, "Monitor & evaluate weight/weight changes" dated 01/12/2016.</p> <p>During an interview on 08/11/2016 at 2:06 P.M., the RD (Registered Dietician) indicated residents were weighed</p>	F 0282	<p>Issue: Weights werenot documented in weights/vitals portal during 5/18/2016 – 6/19/2016 LOS forResident #108 and during 5/10/2016 – 7/29/2016 for Resident #64</p> <p>1.Plan of correction: (actions taken)</p> <p>1.Resident #108 is no longer a resident ofthis facility.</p> <p>2.Resident #64 was weighed 7/29/2016,8/7/2016, 8/14/2016, and 8/21/2016 with gain of 5% identified. Nursing orderswere placed on the electronic nursing MAR, electronic nursing assistant flowsheet, and monitoring for weight changes on the care plan updated as necessary.</p> <p>2.Others at risk: All current residents havepotential to be affected.</p> <p>1.All current residents were weighed andweights recorded. Weights for 2016 were reviewed and responsible partiesnotified with updates and current interventions. Nursing orders were placed onthe electronic nursing MAR, electronic nursing assistant flow sheet, and careplans updated as necessary.</p>	09/16/2016			

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	<p>monthly if a resident did not have an order for weekly or daily weights.</p> <p>During an interview on 08/15/2016 at 2:24 P.M., RN (Registered Nurse) #9 indicated if there was no order for weights then weights were obtained weekly for four weeks after admission and monthly after that.</p> <p>2. The clinical record for Resident #108 was reviewed on 08/11/2016 at 9:08 A.M. The resident was admitted on 05/18/2016 and discharged on 06/19/2016.</p> <p>Diagnoses included, but were not limited to, traumatic subarachnoid hemorrhage with loss of consciousness of unspecified duration, sequela, cerebellar stroke syndrome, acute respiratory failure, chronic obstructive pulmonary disease, and alcohol dependence. Resident #108 received nothing by mouth, received tube feedings, and was severely cognitively impaired.</p> <p>Resident #108's care plan was provided by the Administrator on 08/09/2016 at 2:35 P.M., and reviewed at that time. Included in the care plan, with an initiation date of 05/24/2016, was "Risk for nutritional decline related to: diagnosis of lung CA with mets and receiving all nutritional needs via G-tube</p>		<p>3.Education:</p> <p>1.SDC/designee will provide education to nursingstaff and registered dietician on policy for obtaining weights, process forobtaining weights, and process for review of weight changes.</p> <p>4.Ongoing audits/tools:</p> <p>1.The DNS/designee will monitor weightsweekly for completion and accuracy as an ongoing process of this facility.Insidious or significant weight changes will be identified and discussed in theIDT weekly weight meeting; interventions put into place, notifications anddocumentation completed, and care plans updated, as necessary.</p> <p>2.All findings will be acted upon immediatelyand audit results reviewed in the monthly PI meeting.</p> <p>5.The DNS is responsible for this compliance.</p>	

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	<p>with risk for dehydration". One of the interventions/tasks listed was, "Monitor & evaluate weight / weight changes."</p> <p>Doctor's orders dated 05/19/016 indicated, "...May use feedings of Peptamen at same concentration until novasource renal is available ..."</p> <p>Doctor's orders dated 05/20/016 indicated, "...Enteral Feed Order every night shift for nutritional support infuse via peg tube by pump at 45 ml/hr ..."</p> <p>Doctor's orders dated 05/27/016 indicated, "...D/C previous feeding order. Start feeding of novasource renal 54 ml/hr x 20 hours, off at noon and restart at 4pm ..."</p> <p>During an interview on 08/10/2016 at 2:44 P.M., the District Director of Clinical Operations indicated the only weight she could find in the clinical record was on a Medical Nutrition Therapy Assessment, dated 05/24/2016, of 71 kilograms (156.5 lbs.).</p> <p>During an interview on 08/11/2016 at 2:22 P.M., the RD indicated the resident should have had weekly weights for the first 4 weeks following admission and it was not documented.</p>			

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F 0309 SS=G Bldg. 00	<p>During an interview on 08/11/2016 at 4:28 P.M., the DON (Director of Nursing) indicated the facility had the dietician routinely check the resident including weights, and labs to ensure a resident who received only tube feeding's health was maintained. The DON further indicated weights are checked when there was a change in the tube feed, if the resident develops a wound, or if there are abnormal labs. She also indicated weights are at least checked monthly when residents are admitted.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to provide/administer pain medication to a resident with complaints of pain, following a fall which resulted in a left humeral neck fracture for 1 of 1 resident reviewed for falls with injury and failed to provide education to a resident prior to the</p>	F 0309	<p>Issue: On 7/16/16 Resident #B fell resulting in left humeral neck fracture. The clinical record lacked documentation of pain medication administration until 7/19/16. On 8/10/16 Resident #211 stated he completes his own dressings at times. The clinical record lacked documentation of education with return demonstration of dressing</p>	09/16/2016

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	<p>resident self performing wound treatments for 1 of 1 resident reviewed for patient education.(Resident #211 & #B)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 8/11/16 at 10:30 a.m. Diagnoses included, but were not limited to, legal blindness and dementia. The MDS (Minimum Data Set) assessment, dated 7/12/16, indicated Resident #B had a BIMS (Brief Interview of Mental Status) score of 4, which signified severely impaired cognition.</p> <p>The nurses note, dated 7/17/16 at 3:40 a.m., included, but was not limited to, the following: "...Was called to area in front of nurses station. Resident noted to be on floor in front of wheelchair. Resident buttocks was in the air, resident was face down. Resident assisted to sitting position. Resident confused, not able to describe what he/she was doing before he/she ended up on the floor...denies pain, but is rubbing his/her left arm..."</p> <p>The physician progress note, dated 7/18/16 and untimed, included, but was not limited to, the following: "...Chief Complaint/Nature of Presenting Problem: Acute visit for follow up fall...History of</p>		<p>change until 8/15/16.</p> <p>1.Plan of correction: (actions taken)</p> <p>1.Order for routine and PRN pain medicationwas obtained for Resident #B.</p> <p>2.Self administration of medicationAssessment was completed 8/15/2016. Education with return demonstration of dressing change was provided to Resident #211.</p> <p>2.Others at risk: All current residents havepotential to be affected.</p> <p>1.A chart audit for pain management wascompleted; any discrepancy has been corrected immediately with comprehensivepain assessment, non medication interventions, care plan updates, physiannotification for routine and breakthrough coverage if required, andfamily/responsible party notification of changes.</p> <p>2.An audit of all patients was completed todetermine desires to self medicate; affirmative answers were immediatelyassessed for self administration of medication, followed by physician notifiedand order obtained, education with return demonstration completed, care</p>				

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	<p>Present Illness: Pt [patient] fell over the wkend [weekend] and was complaining of L [left] shoulder pain. X rays were completed and negative. The patient is till complaining of pain and has limited ROM [range of motion]..."</p> <p>The nurses note, dated 7/18/16 at 3:20 p.m., included the following: "...New order received of It [left] rib series r/t [related to] s/p [status post] fall et [and] c/o [complaints of] pain. Pt [patient] seen by NP [Nurse Practitioner] this day."</p> <p>The radiology report, dated 7/18/16 at 7:02 p.m., included, but was not limited to, the following: "...Results...Impacted left humeral neck fracture...Conclusion...Left humeral neck fracture..."</p> <p>The nurses note, dated 7/18/16 at 8:59 p.m., included, but was not limited to, the following: "...x-ray results called to np [nurse practitioner]. new [sic] order received to sent to ER [emergency room] for eval [evaluation] et [and] tx [treatment] r/t [related to] abnormal xray [sic] result..."</p> <p>The July 2016 MAR (Medication Administration Record) indicated, on 7/16/16, Resident #B had a pain level of 3 and on 7/17/16, a pain level of 2. The</p>		<p>plan updated, and responsible party was notified, if indicated.</p> <p>3. Education: 1. SDC/designee will provide education to licensed nurses on Pain Management and Self Administration of Medication to include physicians order, education with return demonstration, and updating the care plan.</p> <p>4. Ongoing audits/tools: 1. The DNS/Designee will audit daily pain monitoring for increases in pain scores 5 days per week for 4 weeks, 3 days per week for 4 weeks, then after falls with morning IDT meeting as an ongoing process of the facility. Any increase in complaints of pain will be followed up to ensure effective intervention was provided. 2. The DNS/designee will audit nursing assessments daily to identify patients desiring to self medicate, completion of assessment, order, education, care plan update, and notification 5 days per week for 4 weeks, then 4 days per week for 4 weeks, then 3 days per week for 4 weeks, then 2 days per week for 4 weeks to identify areas of opportunity. The DNS/designee will audit new admissions and quarterly assessments as an</p>		

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	<p>July 2016 MAR lacked documentation of the administration of pain medication for pain relief. The MAR also indicated Resident #B did not receive any pain medication from the time of the fall on 7/16/16, recorded on 7/17/16 at 3:40 a.m., through discharge to the hospital on 7/18/16 at 8:59 p.m. The clinical record further indicated Resident #B did not receive any pain medication upon return from the hospital on 7/18/16 at 11:48 p.m. until 7/19/16 at 5:18 a.m. for "crying out pain."</p> <p>The hospital discharge record, dated 7/18/16 at 11:12 p.m., indicated Resident #B did not receive any pain medication.</p> <p>During an interview on 8/16/16 at 3:05 p.m., the DDCO (District Director of Clinical Operations) indicated Resident #B was not given pain medication on 7/16/16 or 7/17/16 or prior to hospital discharge.</p> <p>2. The clinical record for Resident #211 was reviewed on 8/11/16 at 1:45 p.m. Diagnoses included, but were not limited to, post traumatic stress disorder, fracture of tibia or fibula following insertion of orthopedic implant, joint prosthesis, or bone plate, left leg, and open wound to the left lower extremity. The admission MDS (Minimum Data Set) assessment,</p>		<p>ongoingprocess of the facility. Any identified areas of opportunity will be correctedimmediately.</p> <p>3.All findings will be acted upon immediatelyand results reviewed in the monthly PI meeting.</p> <p>5.The DNS is responsible for this compliance.</p>		

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	<p>dated 7/20/16, indicated Resident #211 had a BIMS (Brief Interview of Mental Status) score of 13 which signified intact cognition.</p> <p>On 8/10/16 at 10:02 a.m., Bacitracin ointment was observed on Resident #211's bed side table. Dressing supplies were also observed on top of a built in dresser, which included, ABD pads, tape, scissors, and 4 x 4 gauze.</p> <p>During an interview on 8/10/16 at 10:02 a.m., Resident #211 indicated he/she does his/her own dressing changes, at times, to his/her left lower leg. Resident #211 also indicated staff told him/her that he/she could do the dressing changes and he/she just did the dressing change this morning.</p> <p>The August 2016 TAR (Treatment Administration Record) included, but was not limited to, the following: "...Bacitracin Ointment 500 unit/gm [gram] Apply to bilateral legs leg [sic] topically every shift for site care...."</p> <p>The nurses note, dated 8/8/16 at 7:00 p.m. and created on 8/9/16 at 9:45 a.m., indicated Resident #211 completed his/her own treatment to the left lower extremity.</p>			

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	<p>During an interview on 8/15/16 at 3:40 p.m., the Unit Manager indicated she was not aware of Resident #211 doing his/her own dressing changes.</p> <p>During an interview on 8/15/16 at 3:42 p.m., RN (Registered Nurse) #15 indicated Resident #211 has, on occasion, completed his/her own treatment to his/her left lower extremity.</p> <p>During an interview on 8/17/16 at 9:50 a.m., Resident #211 indicated, since admission, he/she has done the treatment to his/her left lower extremity ten times or better.</p> <p>The physician order, dated 8/15/16 at 4:12 p.m., included, but was not limited to, the following: "...May perform own dressing changes..."</p> <p>The Education Record (Patient/Family), dated 8/15/16 at 4:15 p.m., included, but was not limited to, the following: "...Who was trained...patient...Education Needs...Procedure/Treatment...Specific Information Taught...how to complete dressing change and infection prevention...Training Method...Demonstration..."</p> <p>This Federal tag relates to Complaint IN00206249</p>			

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F 0314 SS=D Bldg. 00	<p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>Based on interview and record review, the facility failed to ensure pressure ulcers were monitored appropriately for 1 of 3 residents reviewed for pressure ulcers. (Resident #30)</p> <p>Findings include:</p> <p>Record review for Resident #30 was completed on 08/11/2016 at 9:55 A.M. The resident's Quarterly MDS (Minimum Data Set) assessment, dated 07/05/2016, indicated the resident had a BIMS (Brief Interview for Mental Status) of 99, which</p>	F 0314	<p>Issue: On 3/4/16 Resident #30 was assessed and Stage I pressure area was identified and documented. Resident #30 discharged 3/23/16 with no follow up documentation(BWAT) was found in the clinical record.</p> <p>1. Plan of correction: (actions taken)</p> <p>1. Resident #30 was assessed for impaired skin integrity, findings were documented in the medical record, notifications to physician and responsible party completed and</p>	09/16/2016

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	<p>meant the interview was not completed. The resident's diagnoses included, but were not limited to, hypertension, dementia, and hemiplegia or hemiparesis.</p> <p>Resident #30's "Weekly Pressure Ulcer BWAT [Bates-Jensen Wound Assessment Tool] Report", dated 03/04/2016, indicated the resident had a pressure ulcer on his left heel on admission to the facility. The report included descriptors including, but were not limited to, size, location, shape, stage, edges, and undermining.</p> <p>There were no other weekly pressure ulcer reports found in Resident #30's clinical record.</p> <p>Resident #30's "Weekly Skin Check" assessments on 03/11/2016 and 03/18/2016 indicated the resident had a pressure ulcer on his left heel, but contain no further information regarding the pressure ulcer.</p> <p>During an interview on 08/11/2016 at 10:24 A.M., the DON (Director of Nursing) indicated pressure ulcers were assessed weekly. She further indicated that assessment included measurements, staging, a description of the wound, and evaluation of the wound treatment.</p>		<p>documented, new order transcribed to the appropriate flow sheet and plan of care updated, as necessary based on findings.</p> <p>2.Others at risk: All current residents have the potential to be affected.</p> <p>1.All current residents were assessed for impaired skin integrity, findings were documented in the medical record, notifications to physician and responsible party completed and documented, new orders transcribed to the appropriate flow sheet and plan of care updated, as necessary based on findings.</p> <p>2.A schedule was created to pair weekly skin assessments with residents individual shower schedule.</p> <p>3.Education:</p> <p>1.SDC/designee will provide education to licensed nurses regarding completion and accuracy of the medical record; specifically, thorough assessment and documentation of skin integrity to include follow up assessment and documentation of skin integrity.</p>				

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F 0323 SS=D Bldg. 00	<p>During an interview on 08/15/2016 at 9:44 A.M., the DON indicated she could not find any more documentation regarding Resident #30's pressure ulcer in the resident's clinical record.</p> <p>During an interview on 08/15/2016 at 2:20 P.M., RN #9 indicated the pressure BWAT was completed every week when a resident had a pressure ulcer.</p> <p>The current facility policy, titled "Pressure Ulcer/Skin Alteration Assessment" and dated 05/02/2016, was provided by the DDCO (District Director of Clinical Operations) on 08/15/2016 at 10:12 A.M. and was reviewed at that time. The policy indicated, "...Document in Point Click Care on the Weekly Pressure Ulcer Condition Report...Document in the patient's medical record the measurements of of [sic] the wound in centimeters (cm). Document One wound site per assessment. Weekly Pressure Ulcer BWAT Report..."</p> <p>3.1-40(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p>		<p>4.Ongoing audits/tools:</p> <p>1.The DNS/designee will audit weekly skinassessments and weekly pressure ulcer assessments for completion and accuracyin adjunct with resident observation five times weekly for 4 weeks, then 4 timesweekly for 4 weeks, then 3 times weekly for 4 weeks, then 2 times weekly for 4weeks to identified areas of opportunity will be corrected immediately.</p> <p>2.The weekly skin report will be compared todocumentation in the medical record and observation as an ongoing process ofthis facility.</p> <p>3.All findings will be acted upon immediatelyand results reviewed in the monthly PI meeting.</p> <p>5.The DNS is responsible for this compliance.</p>		

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	<p>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. Based on interview and record review, the facility failed to provide adequate supervision to prevent the potential for additional physical abuse to occur after a resident (Resident #16) returned from a behavioral hospital stay related to physical abuse towards another resident (Resident #99).</p> <p>Findings include:</p> <p>The clinical record for Resident #16 was reviewed on 8/11/16 at 9:25 a.m. Diagnosis included, but were not limited to, dementia with behavioral disturbance.</p> <p>The incident report, dated 7/14/16 at 15 p.m., included, but were not limited to, the following: "...Residents involved... [Resident # 16's name]...[Resident #99's name]...Brief Description of Incident...Staff heard resident in [Resident #99's room number] yelling for help...[Resident #16's initials] was found holding [Resident #99's initials] down leaning on his chest. [Resident #99's initials] was found to have a bruised eye...Type of Injury...[Resident #99's initials] sustained a purple bruise, swelling and small cut under...left</p>	F 0323	<p>Issue: On 7/14/16 resident #16 held resident #99 down on bed and hit him in the face.</p> <p>1. Plan of correction: (actions taken)</p> <p>1. Resident #16 is no longer a resident of this facility.</p> <p>2. Others at risk: All current residents have potential to be affected.</p> <p>1. A chart audit of the past 30 days was completed to identify residents' at risk for exhibiting challenging behaviors.</p> <p>2. Any resident identified to have distressing behaviors in the past 30 days will have a behavior assessment and IDT review completed to ensure appropriate interventions are developed to reduce and/or eliminate the cause of distressing behaviors including but not limited to ensuring the appropriate level of supervision is provided. Care sheets, behavior monitoring tools, and care plans will be updated immediately, as necessary.</p> <p>3. Residents and staff have been interviewed related to abuse. Any negative answer</p>	09/16/2016

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	<p>eye...Immediate Action...The nurses separated the residents...[Resident #99's initials] was evaluated by the nurse...sent to [name of hospital] Emergency Department...Preventative Measures... [Resident #99's initials] was transported to [name of hospital] Emergency Department for evaluation and treatment...received a CT of the spine, face and head...A steri strip was placed on the laceration under the eye..."</p> <p>The typed witness statement, undated and untimed, included, but was not limited to, the following: "Resident...reported to me that on...way to room...witnessed [Resident #16's room number] standing in the doorway of [Resident #99's room number] asking...to let...outside. Resident...continued going to...room and a few minutes later when...came out of...room, ...witnessed [Resident #16's room number] holding [Resident #99's room number] down on the bed and hitting him in the face with...fist...[Social Services signature]..."</p> <p>The nurses note, dated 6/30/16 at 2:20 p.m., included, but was not limited to, the following: "...Received call for [name of psychiatric hospital] with update on resident. States [Resident #16's first name] has been combative and verbally aggressive with staff and peers. Has been</p>		<p>will be followed up immediately with appropriate action i.e. Allegation of abuse – removal of alleged abuser (if staff member immediate suspension), physical assessment and psychosocial assessment, reportable event, and launch investigation.</p> <p>3. Education: 1. SDC/designee will provide education to staff related to responsibilities on Abuse, What Constitutes Abuse, Reporting Requirements, and intervention implementation for residents displaying challenging/distressing behaviors. 2. SDC/designee will provide education to staff regarding completion and accuracy of the medical record; specifically, thorough assessment and documentation of challenging/distressing behaviors.</p> <p>1. Ongoing audits/tools: 1. The SSD/designee will audit behavior monitoring records 5 days per week for 4 weeks, then 4 days per week for 4 weeks, then 3 days per week for 4 weeks, then 2 days per week for 4 weeks to identify areas of opportunity and</p>	

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	<p>in a physical altercation with another peer..."</p> <p>The nurses note, dated 7/12/16 at 12:39 a.m., indicated Resident #16 was readmitted to the facility from the psychiatric hospital.</p> <p>The behavior note, dated 7/12/16 at 9:22 p.m., included, but was not limited to, the following: "...Resident refusing to go to bed, wandering into other residents [sic] rooms, being verbal [sic] aggressive to others, [sic] tried to hit this nurse and cna [sic] with cane, [sic] assisted to lounge area but refuses to sit down, yelling out and cursing loudly upsetting other residents. Also beating on 200hall [sic] exit doors causing alarm to go off, [sic] was assisted away from doors per other male nurse but continued to be aggressive..."</p> <p>The behavior note, dated 7/14/16 at 1:52 p.m., included, but was not limited to, the following: "...[Resident #99's room number] was yelling, "Help" from room. This nurse and nurse 2 entered room and noted resident [Resident #16] on top of [Resident #99's room number] with both arms across [Resident #99's room number] neck. [Resident #99's room number] head was turned to the left and pressed into the mattress. Resident</p>		<p>implement interventions to address causal factors including but not limited to the appropriate level of supervision. IDT review will be completed to ensure appropriate interventions were developed to reduce and/or eliminate the cause of distressing behaviors. Care sheets, behavior monitoring tools, and care plans will be updated as necessary.</p> <p>2. The SSD/designee will review behavior monitoring documentation monthly; residents will be reassessed quarterly, annually, with significant change, or more frequently, if deemed necessary, by the interdisciplinary team to ensure appropriate interventions to reduce and/or eliminate the cause of distressing behaviors are updated, as necessary, as an ongoing process of this facility.</p> <p>3. The IDT will complete 40 Resident, Family, and Staff interviews every 6 month cycle as an ongoing process of this facility in an effort to identify, correct and intervene in situations in which abuse, neglect and/or misappropriation of resident property are more likely to occur.</p>				

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	<p>[Resident #16] appeared to be choking [Resident #99's room number]..."</p> <p>The physician's progress note, dated 7/14/16, included, but was not limited to, the following: "...[Resident #16's name]...Chief Complaint/Nature of Presenting Problem: Acute visit for readmission post hospital stay...History of Present Illness: Pt [patient] also just had an altercation with another resident in which staff found him on top of the other resident attempting to choke him. It is now known what provoked him, if anything..."</p> <p>On 8/15/16 at 1:07 p.m., during an interview with LPN (Licensed Practical Nurse) #19, she indicated she was working on the day of the incident between Resident #16 and Resident #99 and responded to Resident #99's call for help. LPN #19 indicated Resident #16 was laying on top of Resident #99 with his forearm across Resident #99's neck. LPN #19 also indicated Resident #16 wandered a lot. LPN #19 further indicated it appeared Resident #16 was choking Resident #99.</p> <p>The clinical record lacked documentation of increased supervision upon Resident #16's readmission on 7/12/16, following a psychiatric hospital stay.</p>		<p>4.The DNS/designee will review documentation5 days / week for 3 months to identify circumstances of potential abuse,immediately follow up with necessary steps, and education of staff.</p> <p>5.All findings will be reported to the EDimmediately and reported in monthly PI meeting. Abuse education and Resident Rights will continue to be provided in newemployee orientation and annually.</p> <p>2.The ED is responsible for this compliance.</p>				

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F 0431 SS=D Bldg. 00	<p>During an interview on 8/15/16 at 12:42 p.m., when asked why increased supervision was not initiated for Resident #16 after his/her return from a psychiatric hospital stay, the DON (Director of Nursing) indicated she would have to look at what they knew prior to Resident #16 returning from the hospital.</p> <p>During an interview on 8/15/16 at 1:30 p.m., the Social Services Director indicated Resident #16 had not had any behaviors at the psychiatric hospital for 72 hours prior to his/her readmission.</p> <p>3.1-45(a)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently</p>						

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	<p>accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper medication storage was maintained related to accurate narcotic counts and expired medications for 2 of 5 medication carts reviewed. (Harmony Way cart and 200 Hall cart)</p> <p>Findings include:</p> <p>1. During an observation and interview of the Harmony Way medication cart on 08/16/2016 at 1:17 P.M., a random narcotic count was completed with LPN (Licensed Practical Nurse) #13. Resident #46's narcotic count for</p>	F 0431	<p>Issue: Narcotic count record for Resident #46 and Resident #83 was not updated at time of administration. Expired Breo Ellipta inhaler for Resident #166 was stored in medication cart.</p> <p>1. Plan of correction: (actions taken)</p> <p>1. Narcotic count record for Resident #46 and Resident #83 was updated to include medications administered during shift. Narcotic count was completed and accurate. Performance Improvement was provided to LPN #13.</p> <p>2. Expired Breo Ellipta inhaler for Resident #166 was removed from medication cart</p>	09/16/2016			

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	<p>hydrocodone-acetaminophen 5-325 mg (milligrams) showed a current count of 21. There were 19 tablets remaining in the medication card. LPN #13 indicated one tablet of hydrocodone had been given twice that day, but neither had been signed out by the nurse on duty. Resident #83's narcotic count sheet for tramadol hcl (hydrochloride) 50 mg showed a current count of 9. There were 8 tablets remaining in the medication card. LPN #13 indicated the medication had not been signed out by the nurse on duty. The LPN further indicated narcotic medication should be signed out in the narcotic book as soon as it was given.</p> <p>The current facility policy, titled "Management and Destruction of Controlled Substances" and dated 06/01/2016, was provided by the DDCO (District Director of Clinical Operations) on 08/16/2016 at 2:57 P.M. and was reviewed at that time. The policy indicated, "...Record Keeping - a declining inventory sheet is maintained on each individual controlled substance in a binder or book that documents administration and the wasting of each dose..."</p> <p>2. During an observation and interview of the 200 Hall medication cart on 08/16/2016 at 1:26 P.M., Resident #166's</p>		<p>and disposed of per regulations. Performance Improvement was provided to LPN #12.</p> <p>2.Others at risk: All residents receiving medications are at risk.</p> <p>1.All carts were audited for expired medications and complete and accurate narcotic counts. Any discrepancy was corrected immediately.</p> <p>3.Education: 1.SDC/designee will provide education to licensed nurses related to Medication Management: Narcotic Count Process and Expired Medication Removal and destruction.</p> <p>4.Ongoing audits/tools: 1.The DNS/designee will perform cart audits for compliance five times weekly for 30 days, than 3 times weekly for 30 days, followed by 2 times weekly for 30 days, then monthly as an ongoing practice. All findings will be acted upon immediately and results reviewed in the monthly Pl meeting.</p> <p>5.The DNS is responsible for this compliance.</p>		

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F 0514 SS=D Bldg. 00	<p>Breo Ellipta inhaler had an open dated of 07/01/2016 and an expiration date of 08/11/2016. LPN # 12 indicated the medication should have been disposed when it expired.</p> <p>The current facility policy, titled "Inhaled Medications" and dated 09/29/2015, was provided by the DDCO on 08/16/2016 at 2:57 P.M. and was reviewed at that time. The policy indicated, "...Breo Ellipta Inhalation Powder...discard 6 weeks after removal from foil pouch..."</p> <p>The current facility policy, titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" and dated 12/01/2007, was provided by the DDCO on 08/17/2016 at 12:57 P.M. and was reviewed at that time. The policy indicated, "...Facility should ensure that medications and biologicals...Have not been retained longer than recommended by manufacturer or supplier guidelines..."</p> <p>3.1-25(o)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented;</p>				

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	<p>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 resident documentation was complete and accurate related to signs of anxiety before use of anti-anxiety medication for 1 of 5 residents reviewed for medications. (Resident #147)</p> <p>Findings include:</p> <p>Record review for Resident #147 was conducted on 08/11/2016 at 8:29 A.M. The Significant Change MDS (Minimum Data Set) assessment, dated 05/05/2016, indicated the resident had a BIMS (Brief Interview for Mental Status) of 08, which meant the resident had cognitive impairment. The diagnoses included, but were not limited to, anxiety and bipolar disorder.</p> <p>Resident #147's July, 2016 MAR (Medication Administration Record) indicated the resident had an order for Lorazepam (antianxiety</p>	F 0514	<p>Issue: Signs of anxiety were not documented as exhibited prior to administering a PRN anxiolytic to Resident #147.</p> <p>1. Plan of correction: (actions taken)</p> <p>1.A review of Resident #147's records was completed to identify each time the PRN anxiolytic was administered without documented signs of anxiety. 1:1 education related to documentation responsibilities was provided to each nurse identified in audit.</p> <p>2. Others at risk: All residents receiving PRN psychoactive medications are at risk.</p> <p>1. An audit of medication orders for all residents was completed to identify all orders for PRN psychoactive medications.</p> <p>2. Each resident identified as receiving PRN psychoactive medication documentation was reviewed to ensure side effects of medication use, non medication interventions and</p>	09/16/2016

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	<p>medication) 1 mg (milligram) every six hours as needed for anxiety. The medication was given 22 times during July. There was an order for behavior monitoring related to Resident #147's anxiolytic medication use. There was one episode of anxiety documented on the MAR for July.</p> <p>Resident #147's August, 2016 MAR indicated the resident had an order for Lorazepam 0.5 mg one time a day as needed for anxiety. The medication was given three times during August. There was an order for behavior monitoring related to Resident #147's anxiolytic medication use. There were no episodes of anxiety documented on the MAR for August.</p> <p>During an interview on 08/15/2016 at 5:02 P.M., the DON (Director of Nursing) indicated staff should have been documenting episodes of anxiety related to Resident #147's use of as needed anti-anxiety medication.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>		<p>symptom monitoring was inplace.</p> <p>3.A 30 day review of the records was completeto determine if PRN medication was administered without documentation of signsof associated behavior; 1:1 education was provided to the Licensed NurseAdministering. If the Resident did not receive the medication for 30 days apsychotherapeutic medication review and order for discontinuation wasrequested.</p> <p>3.Education:</p> <p>1.SDC/designee will provide education tolicensed nurses regarding completion and accuracy of the medical record;documentation of side effects of medication use, non medication interventionsand symptom monitoring for PRN psychoactive medication administration.</p> <p>4.Ongoing audits/tools:</p> <p>1.The DNS/designee will review medication recordsfor documentation of side effects of medication use, non medication interventionsand symptom monitoring for PRN psychoactive medication administration 5 daysper week for 4 weeks, then 4 days per week for 4 weeks, then 3 days per weekfor 4 weeks, then 2</p>		

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F 9999 Bldg. 00	<p>3.1-14 PERSONNEL</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment...(3) The facility shall maintain a health record of each employee that includes: (A) a report of the pre-employment physical examination</p> <p>This rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure each employee's pre-employment</p>	F 9999	<p>days per week for 4 weeks to identify areas of opportunity. Identified areas of opportunity will be corrected immediately. Documentation of psychoactive medication usage including side effects of medication use, nonmedication interventions and symptom monitoring will be reviewed with the monthly IDT behavior meeting as an ongoing process of this facility. All findings will be acted upon immediately and results reviewed in the monthly PI meeting.</p> <p>5. The DNS is responsible for this compliance.</p> <p>Issue: Pre-employment physical forms were incomplete for 5 of 10 employee records reviewed.</p> <p>1. Plan of correction: (actions taken)</p> <p>1. The 10 employees records reviewed werere-evaluated. An employee physical was completed for each employee reviewed.</p> <p>2. Others at risk: All residents have potential to be affected by an employee with communicable diseases.</p> <p>1. Employee physicals must be completed on</p>	09/16/2016

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	<p>physical forms were completed for 5 of 10 employee records reviewed. (CNA #1, #3, #4, #5, & LPN #2)</p> <p>Findings include:</p> <p>Employee records were reviewed on 08/17/2016 at 10:00 A.M. Facility Employee Health Certifications that were signed by Nurse Practitioners, were not completed for CNA (Certified Nurse Aide) #1, #3, #4, #5, and LPN (License Practical Nurse) #2.</p> <p>During an interview on 08/17/2016 at 10:51 A.M., the District Director of Clinical Operations indicated she would expect the form to be completed and followed up on. She further indicated the SDC (Staff Development Coordinator) takes care of the forms for new employees.</p> <p>During an interview on 08/17/2016 at 11:03 A.M., the Staff Development Coordinator indicated it was the Nurse Practitioner's job to complete the part of the Health Certification form related to communicable diseases and the ability to perform the job satisfactorily. It was her job to review the completed forms.</p> <p>The Pre Hire Post offer Checklist,</p>		<p>allcurrent employees.</p> <p>3.Education: 1.DDCO/designee will provide education to theSDC and NP regarding completing pre-employment health screening.</p> <p>4.Ongoing audits/tools: 1.The SDC/Designee will bring completed newhire Health/Education/Licensure files to the DNS/Designee for review prior tothe employee being released to floor orientation as an ongoing process of thisfacility. Employee Health/Education/Licensure will be reviewed for completionmonthly based on date of anniversary by the DNS/designee prior to PI as anongoing practice. All findings will be acted upon immediately and resultsreviewed in the monthly PI meeting.</p> <p>5.The DNS is responsible for this compliance.</p>				

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	provided by the District Director of Clinical Operations on 08/17/2016 at 2:46 P.M., indicated physicals were to be verified or completed by the SDC.				