

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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F000000	<p>This visit was for the Investigation of Complaints IN00146590, IN00146612, IN00147099 and IN147218.</p> <p>Complaint IN00146590 Substantiated, no deficiencies related to the allegations were cited.</p> <p>Complaint IN00146612-Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00147099-Substantiated, no deficiencies related to the allegations were cited.</p> <p>Complaint IN00147218-Substantiated, deficiency related to the allegations is cited at F-281.</p> <p>Unrelated deficiency is cited.</p> <p>Survey Dates: April 7, 8, 9, 10 & 11, 2014.</p> <p>Facility number: 000283 Provider number: 155586 AIM number: 100275020</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: SNF/NF: 107 Residential: 50 Total: 157</p> <p>Census payor type: Medicare: 23 Medicaid: 84 Other: 50 Total: 157</p>	F000000	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>This Plan of Correction is prepared and submitted because of requirements under State law.</p> <p>We respectfully request paper compliance for the corrective actions described herein.</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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F000280 SS=D	<p>Sample: 9</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 14, 2014 by Randy Fry RN. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to assess and write activity care plans for 2 of 2 residents reviewed for activity care planning(B & C) who resided on the Rehabilitation Unit.</p> <p>Findings include:</p> <p>1. On 4/10/14 at 10:00 a.m. review of the clinical record for resident (B) indicated he was admitted to the facility on 4/4/14 with</p>	F000280	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State law. We respectfully request paper compliance for the corrective actions described herein. F280 The facility affords each resident	05/11/2014			

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	<p>diagnoses including but not limited to Femoral Neck Fracture, Coronary Artery Disease, and Urinary Tract Infection. The resident was noted to be in isolation due to an infection.</p> <p>Review of the clinical record did not indicate the resident had been assessed for activities, and the resident was in isolation and kept in his room. Review of CNA (Certified Nursing Assistant) care sheets, indicated there was no documentation of the resident's activity needs.</p> <p>2. Review of the clinical record for resident (C) on 4/10/14 at 10:30 a.m. indicated he was admitted to the facility on 1/5/14 with diagnoses including but not limited to Cervical Stenosis, Post Cervical Laminectomy, Chronic Kidney Disease and Diabetes.</p> <p>Review of the clinical record did not indicate the resident had been assessed or a care plan written for his activity interests and needs. Review of the CNA care sheets, indicated there was no documentation of the resident's activity needs.</p> <p>On 4/10/14 at 2:00 p.m. interview with the Social Service Director for the Rehabilitation Hall indicated she did not know who was responsible for resident activity documentation and care planning. She indicated resident (B's) assessment period ends on 4/11/14 and indicated he likes to watch TV and has a lot of visitors. She indicated he receives chaplain services. The Social Worker indicated resident (C) likes to stay in his room and visits with his family and other patients. She indicated he had a lot of visitors.</p>		<p>the right to participate in planning care and treatment, and develops a comprehensive care plan within 7 days after the comprehensive assessment. Corrective action for residents affected: Residents B and C have had individualized activity care plans developed with input from the residents. Interventions have been implemented. Other residents having the potential to be affected and corrective actions: All residents on the rehabilitation unit have the potential to be affected by this deficient practice. Individualized care plans have been developed with input from the residents. Interventions have been implemented. Measures to ensure practice does not recur: Facility policy regarding activity assessment and care planning has been reviewed and revised to ensure all residents have a comprehensive care plan developed within 7 days after the applicable assessment has been completed. Residents are encouraged to participate in development of individualized activity/leisure programming that reflects each resident's preferences and physical abilities. Activity department staff or designees have been educated on the current policy and procedure. This corrective action will be monitored by: Activity Director or designee will complete audits of activity care</p>		

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	<p>On 4/11/14 at 1:30 p.m. interview with CNA #14 indicated residents on the rehabilitation Hall get calendars of the activities that are available and that they take them to activities of interest which are located in other parts of the building.</p> <p>On 4/11/14 at at 2:00 p.m. review of the facility policy for "Activities" dated 3/12 indicated the following:</p> <p>To provide for official, comprehensive written records of all resident's interests and involvement in activity programs including group and individual.</p> <p>Policy Interpretation and Implementation</p> <ol style="list-style-type: none"> 1. The Activity Department employees are responsible for the completion of all required resident documentation within the specified time frames for each neighborhood. 2. Activity Department employees will complete documentation regarding Resident Activities, individual and group. <ol style="list-style-type: none"> a. The Activity Department employees are responsible for completion on the following documentation in Optimus. b. MDS (Minimum Data Set) CAA Summaries c. Care Plans d. Progress Notes 3. All Activity Department employees will document the following on paper forms, 		<p>plans on the rehabilitation unit once per week for three months, then once every two weeks for three months or until 100% compliance is achieved. Trends in audits results will be reported to the QA Committee. Additional corrective actions will be developed by the committee as deemed necessary. Exhibit A.</p>	

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F000282 SS=D	<p>a. Activity Assessments</p> <p>b. Daily Resident Activity Attendance Records.</p> <p>c. Resident One To One documentation.</p> <p>4. The Activity Director or designee will audit all Activity Documentation as needed.</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(c)(1) 3.1-35(2)(A)(B)(C) 3.1-35(d)(1)(2) 483.20(k)(3)(ii)</p> <p>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview the facility failed to follow physician orders to ensure 1 resident (A) in a sample of nine resident records reviewed, used a back brace when out of bed as ordered by the physician.</p> <p>Finding Includes:</p> <p>Review of the clinical record for resident (A) on 4/8/14 at 9:30 a.m. indicated she was admitted to the facility on 3/13/14 with diagnoses including but not limited to Compression Fracture of L2 (Lumbar) and L3, Diabetes and Hypertension. Review of physician orders dated 3/13/14 indicated "Brace to be on at all times when up."</p> <p>On 4/8/14 at 9:30 a.m. review of nursing notes dated 3/14/14 at 4:23 p.m. indicated</p>	F000282	<p>Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State law. We respectfully request paper compliance for the corrective actions described herein. F282 The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Corrective action for residents affected: Resident A was transferred to the hospital for evaluation per MD</p>	05/11/2014

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	<p>"Patient was up to be weighed this morning with assist of PT (Physical Therapist). Patient wishes to stay in bed and at this time is refusing pain meds related to her fear of the pain meds interfering with her Coumadin. Patient is leaning to the right in bed. Patient somewhat confused and forgetful related to morning med pass, patient forgot that writer administered her eyedrops."</p> <p>Interview with the Physical Therapist on 4/8/14 at 3:00 p.m. indicated she had been asked by nursing to assist with weighing the resident. She indicated a CNA (certified nursing assistant) and herself got the resident out of bed and placed her in a wheelchair. The resident was taken down the hall and weighed in her wheelchair and returned to bed. The Physical Therapist indicated she knew the resident had compression fractures but did not know she was to wear a back brace when out of bed.</p> <p>On 4/11/14 at 10:20 a.m. review of the Facility Policy , "Admission Orders" dated 1/31/11 indicated "It is the intention of Lutheran Home to promptly obtain physician orders from the previous provider of a new admission."</p> <p>This Federal Tag is related to Complaint IN00147218</p> <p>3.1-35(g)(2)</p>		<p>order on March 14, 2014. Resident A was subsequently discharged from the facility. Other residents having the potential to be affected and corrective actions: All residents have the potential to be affected by this deficient practice. New physician orders are reviewed daily and applicable staff is informed of orders that affect assigned duties. Measures to ensure practice does not recur: Facilities policies related to transcribing, verifying, and timely implementation of new physician orders have been reviewed and revised as deemed necessary to ensure the practice does not recur. Applicable staff has been educated on current facility policy related to timely implementation of new physician orders. This corrective action will be monitored by: Unit Managers will continue to review all new physician orders daily Monday through Friday and update CNA Assignment Sheets with any orders that affect CNA duties. Night shift charge nurses will continue to verify that all orders written within the previous 24 hours, including new admission orders, were properly transcribed, and will identify in writing if follow-up is needed. Documentation of this order verification will be reviewed by the Night Shift House Supervisor/designee, and submitted to the Director of</p>		

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			Nursing. This process will be on-going. The Director of Nursing or designee will maintain written evidence that physician order verification has occurred daily Monday through Friday for the next three months until 100% compliance is achieved. A summary of verification findings will be presented to the QA Committee. Additional corrective actions will be developed by the committee as deemed necessary. Exhibit B.	