

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155680	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2013
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NAME OF PROVIDER OR SUPPLIER HOMEWOOD HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2494 N LEBANON ST LEBANON, IN 46052
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: August 5, 6, 7, 8, and 9, 2013</p> <p>Facility number: 002703 Provider number: 155680 AIM number: 200309250</p> <p>Survey team: Lora Brettnacher, RN, TC Jeanna King, RN Karen Hartman, RN Shannon Pietraszewski, RN</p> <p>Census bed type: SNF: 24 SNF/NF: 35 Residential: 34 Total: 93</p> <p>Census payor type: Medicare: 18 Medicaid: 23 Other: 52 Total: 93</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state</p>	F000000	<p>The submission of this Plan of Correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Homewood Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</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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	findings cited in accordance with 410 IAC 16.2. Quality review completed on 08/19/2013 by Brenda Marshall Nunan, RN.				

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F000242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents were given a choice of bathing preferences and when to get up in the morning for 2 of 18 residents interviewed for choices. (Resident #19 and #124)</p> <p>Findings include:</p> <p>1. Resident #19 was interviewed on 8/5/13 at 1:20 p.m. Resident #19 indicated she did not get to choose whether she wanted take a shower, tub, or bed bath. Resident #19 indicated there was "only one choice around here." Resident #19 indicated she knew there was a bath tub in the facility but had not seen it.</p> <p>Resident #19's record was reviewed on 8/7/13 at 8:43 a.m. Resident #19's diagnoses included, but were not limited to, transient ischemic attacks (mini strokes), atrial fibrillation (irregular heart rhythm), congestive</p>	F000242	Resident #19 and #124 have been interviewed with regard to their bathing preferences and wake-up times. Wake-up times and bathing preferences have been adjusted per their request and communicated to staff. All residents have been interviewed with regard to current bathing preferences and wake-up times. Wake-up times and bathing preferences have been adjusted per their request and communicated to staff. All new residents are interviewed upon admission with regard to bathing preferences, how often to be given, and what time they would like to wake up. Residents or resident designee will be interviewed at Resident First meetings (Care Conferences), about any changes that they would like to occur with regard to their bathing preferences, how often to be given, or wake-up times. Changes will be communicated to staff. Resident First Meeting audits will be conducted on a weekly basis by the DHS or designee for 90 days,	09/11/2013			

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	<p>heart failure, edema, and left hip replacement.</p> <p>Review of the Resident Preference for Customary Routine and Activities Interview worksheet dated 7/18/13, indicated it was important for the resident to choose her bathing preferences.</p> <p>An interview with the DoN on 8/8/13 at 11:00 a.m., indicated the facility needed to revise their admission questions to be more specific to the resident in regards to choices.</p> <p>2. Resident #124 was interviewed on 8/5/13 at 1:34 p.m. Resident #124 indicated she did not get to choose what time she got up in the morning and did not get to choose how many times a week she took a bath or a shower. Resident #124 indicated the staff woke her up too early in the morning and the facility chose how often a resident got a bath or a shower.</p> <p>Resident #124's record was reviewed on 8/7/13 at 10:00 a.m. Resident #124's diagnosis included, but were not limited to, congestive heart failure.</p> <p>Review of the Resident Preference for Customary Routine and Activities</p>		and then monthly thereafter for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.				

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	<p>Interview worksheet dated 7/28/13, indicated the resident normally would wake herself up around 6:00-7:00 a.m. The form did not indicate how often the resident would like to receive a shower/bath.</p> <p>An interview with the DoN on 8/8/13 at 11:00 a.m., indicated the facility needed to revise their admission questions to be more specific to the resident in regards to choices.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>			

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F000248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents with cognitive impairment were provided activities they were assessed to enjoy. This deficient practice affected 1 of 6 cognitively impaired residents reviewed for activities (Resident #68).</p> <p>Findings include:</p> <p>Resident #68's record was reviewed on 8/7/2013 at 10:24 A.M. Resident #68 had diagnoses which included, but were not limited to, dementia, stroke, depression, and anxiety. Resident #68 was currently a hospice patient. A significant change MDS (minimum data assessment tool) dated 5/20/2013, indicated Resident #68 was not comatose, could not speak but understood others, had adequate vision and hearing, his long term memory was intact, he was totally dependent on staff for bed mobility and transfers, and had severely impaired decision making</p>	F000248	Resident #68's TV is turned on while he is in bed. Resident has been re-evaluated using the 1 on 1 Programming Needs Worksheet (PNW) to determine the appropriate number of 1 on 1 activities provided to meet his needs. Nursing and activity staff have been in-serviced on the importance of making sure Resident # 68's TV is turned on while resident is in his room. All resident receiving one on one activities have been re-evaluated using the 1 on 1 PNW to determine the appropriate number of 1 on 1 activities provided to meet their needs. All activity staff have been in-serviced on the importance of following the PNW in providing residents needing 1 on 1 activities programming. Residents receiving 1 on 1 programming are evaluated monthly using the PNW to determine the appropriate number of one on one activities needed. 1 on 1 Participation log and the PNW audits will be conducted on a weekly basis by the ED or designee for 90 days, and then monthly thereafter for a total of 6 months. Findings of the	09/11/2013	

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	<p>skills.</p> <p>Resident #68's current care plan, last updated 5/28/2013, indicated, "PLEASE TURN MY TV ON WHEN I AM IN BED.... Please provide me with social interactions and sensory stimulation twice a week. Allow me the opportunity to be socially and mentally engaged. Because of my medical condition I am unable to attend group programs. When you provide me with one on one programs be sure to incorporate topics that interest me. Some of those topics include hunting, fishing, sports, and family. I would like to go outside when the weather is nice. Please turn on my television when I am in bed..."</p> <p>Observations of Resident #68 were made at the following times and dates:</p> <p>8/05/2013 at 10:42 A.M.- In his bed with his eyes open. No television (TV) or music playing.</p> <p>8/6/2013 at 9:15 A.M. - In bed with his eyes open staring at the ceiling. TV was on but he was not positioned to see it.</p> <p>8/7/2013 at 900 A.M.- In bed with his eyes closed. No TV or music playing.</p>		audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.				

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	<p>8/7/2013 at 10:23 A.M.- In a chair in his room with his eyes open. No TV or music playing.</p> <p>8/7/2013 at 12:00 P.M.- In a chair in his room with his eyes open. No TV or music playing.</p> <p>8/7/2013 at 1:20 P.M.- In a chair in his room with his eyes closed. No TV or music playing.</p> <p>8/8/2013 at 10:00 A.M.- In bed with his eyes open. Staring at the ceiling. No TV or music playing.</p> <p>During an interview on 8/8/2013 at 10:07 A.M., the Activity Director indicated Resident #68 still enjoyed any outdoor channel. The Activity Director stated, "He absolutely loves hunting and fishing shows." The Activity Director indicated the TV should have been turned on to a show Resident #68 enjoyed when he was in his room. The Activity Director indicated the activity staff most likely assumed the nursing staff was turning the TV on and the nursing staff most likely assumed the activity staff was turning the TV on for him. The Activity Director indicated Resident #68 did not participate in structured activities but was provided 1:1</p>				

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	<p>activities. The Activity Director indicated she felt Resident #68 responded to her during the 1:1 activities. The Activity Director indicated she was not sure how it was determined two 1:1 activities a week were sufficient to meet Resident #68's needs. At this time, activity attendance records for June, July, and August of 2013, were requested.</p> <p>On 8/8/2013 at 10:30 A.M., with the Activity Director present, activity attendance records for Resident #68 were reviewed. June 2013, activity attendance record indicated Resident #68 was was not provided with activities for the weeks of June 21-June 30, 2013 and July 29-August 4, 2013.</p> <p>3.1-33(a)</p>			
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F000279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop care plans with measurable goals related to accidents, pain, nutrition and activities for 4 of 30 residents reviewed for care plans. (Resident #19, #28, #52, and #68)</p> <p>Findings include:</p> <p>1. Resident #19's record was reviewed on 8/7/13 at 8:43 a.m. Resident #19's diagnoses included, but were not limited to, transient ischemic attacks (mini strokes), atrial</p>	F000279	Resident #52 has been re-evaluated using the PNW to determine the appropriate number of one on one activities needed. Resident #52 has been re-evaluated and receives a minimum of two activities per week. Resident #68's TV is turned on while he is in bed. Resident has been re-evaluated using the 1 on 1 PNW to determine the appropriate number of 1 on 1 activities provided to meet their needs. Nursing and activity staff have been in-serviced by Resident Activity Director/DHS on the importance of making sure	09/11/2013	

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	<p>fibrillation (irregular heart rhythm), congestive heart failure, edema, and left hip replacement.</p> <p>Review of a Restraint/Enabler Circumstance Investigation, dated 7/18/13, indicated the reason for the restraint/enabler request was for positioning and assistance with mobility. Type of restraint/enabler considered was side rails. The investigation indicated the resident had decreased safety awareness related to her confusion, decreased strength/endurance and had a history of falls.</p> <p>A physician note, dated 7/22/13, indicated the resident had a history of transient ischemic attacks (mini strokes), as well as a history of a left hip fracture with replacement, which may have caused previous falls.</p> <p>A Fall Circumstance, Assessment, and Intervention, dated 7/23/13, indicated the resident had an unwitnessed fall in the bathroom. The form indicated upon inspection, the wheel chair was not locked. The resident indicated she was transferring herself and the wheel chair had slipped away. The resident did not call for help. The Fall Risk Re-Assessment section indicated the</p>		<p>Resident #68's TV is turned on while resident is in their room. All residents receiving one on one activities have been re-evaluated using the 1 on 1 PNW to determine the appropriate number of 1 on 1 activities provided to meet their needs. All activity staff have been in-serviced on the importance of following the PNW in providing residents needing 1 on 1 activities programming. Resident #19's ADL Care Plan has been updated to include anti-rollback devise for wheelchair, as an intervention, to be evaluated ongoing at resident first meetings for effectiveness. Resident #122's ADL Care Plan has been updated to include pain prevention/relief as an intervention, to be evaluated ongoing at resident first meetings for effectiveness. A random audit of resident care plans has been conducted to assess appropriate interventions and measurable goals. Staff who document on care plans have been in serviced on interventions with measurable goals. Random audits of 5 care plans will be conducted weekly by the DHS or designee for 90 days, and then monthly thereafter for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.</p>		

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	<p>resident was cognitively impaired which affected safety and judgment, required assistance for transfers, unable to maintain balance while standing without assist, and was mostly an extensive assistance of two people. The prevention update section indicated neurochecks per protocol and hydration. The IDT (Interdisciplinary Team) Review section dated 7/24/13, indicated for the resident to continue with therapy and to have anti-roll backs on the w/c (wheel chair).</p> <p>A Physical Therapy progress note dated 7/25/13, indicated the resident continued to have deficits in transfers and ambulation. The progress note indicated due to safety reasons, the resident required verbal and tactile cues for transfers. The therapy note indicated "continued patient training was required for transfers to improve safety in all functional mobility."</p> <p>Review of an ADL (Activities of Daily Living) care plan dated 7/31/13, failed to include interventions with measurable goals for fall prevention.</p> <p>An interview with the MDS (Minimum Data Set) Coordinator on 8/8/13 at 10:30 a.m., indicated the company had changed the care plans to an</p>						

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	<p>individualized computerized program. The MDS Coordinator indicated the program does not allow entry of specific problems such as accidents. The MDS Coordinator indicated she will have to think of a way for goals and interventions to be measurable and specific. Therefore accidents had to be placed in the ADL section.</p> <p>2. An interview with Resident #122 on 8/6/13 at 11:33 a.m., indicated due to his disease process, he was in the acute pain phase/ "pain storm" at the present time and this was generally controlled with prednisone (anti-inflammatory/steroid) and dilaudid (pain medication). The resident indicated he was unable to take anymore prednisone at this time because he had maximized the dose requirements. The resident indicated he managed his medications.</p> <p>Resident #122's record was reviewed on 8/8/13 at 11:30 a.m. The Resident's diagnoses included, but were not limited to, anxiety disorder and after care for joint replacement.</p> <p>A Pain Circumstance, Assessment, Data Collection and Interventions, dated 7/15/13, indicated the resident had acute moderate pain. The resident was not on a scheduled pain</p>				

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	<p>regimen and activities had been limited due to the pain. The Pain Risk Re-Assessment section indicated the resident had a history and diagnosis of chronic pain and the pain contributed to mobility impairment. The Prevention/Relief update indicated to position for comfort, medicate per physician order and evaluate the effectiveness of the pain medication.</p> <p>Review of an ADL (Activities of Daily Living) care plan dated 7/31/13, did not indicate interventions to reduce pain with measurable goals.</p> <p>An interview with the MDS Coordinator on 8/8/13 at 10:30 a.m., indicated the company had changed the care plans to an individualized computerized program. The MDS Coordinator indicated the program did not allow entry of specific problems such as pain. The MDS Coordinator indicated she would have to think of a way for goals and interventions to be measurable and specific. Therefore pain had to be placed in the ADL section.</p>			

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	<p>3. Resident #52's record was reviewed on 8/7/2013 at 10:08 A.M. Resident #52 had diagnosis which included, but were not limited to, mild dementia, clostridium difficle, and congestive heart failure. Resident #52 was receiving hospice services. A Significant Change MDS (minimum data assessment tool) dated 4/9/2013, indicated it was very important for Resident #52 to attend her favorite activities and participate in religious services and/or activities. A quarterly MDS dated 7/5/2013, indicated Resident #52 had adequate hearing and vision, and was unable to speak.</p> <p>Resident #52's current care plan dated 8/5/2013, indicated, "...I enjoy being around others but I am not always able to voice the programs I wish to attend. Because of my medical decline I am counting on staff to provide me with 1:1 activity programs and to escort me to church programs. I also would like to attend special events and musical programs when I am having a good day.... I like to have my fingernails painted.... I also like to be around animals. Please make sure the pets visit with me when they are in the building...." The plan of care lacked</p>				

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	<p>documentation of measurable interventions and goals.</p> <p>During an interview on 8/8/2013 at 9:28 A.M., the Activity Director indicated Resident #52's care plan lacked measurable goals related to frequency of participation in activities for Resident #52. The Activity Director was queried regarding who was responsible for interventions and how they were evaluated. The Activity Director stated, "There is no way to evaluate or to know who is responsible."</p> <p>4. Resident #68's record was reviewed on 8/7/2013 at 10:24 A.M. Resident #68 had diagnoses which included, but were not limited to, dementia, stroke, depression, and anxiety. Resident #68 was currently a hospice patient. A significant change MDS (minimum data assessment tool) dated 5/20/2013, indicated Resident #68 was not comatose, could not speak but understood others, had adequate vision and hearing, his long term memory was intact, he was totally dependent on staff for bed mobility and transfers, and had severely impaired decision making skills.</p> <p>Resident #68's current care plan, last</p>				

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	<p>updated 5/28/2013, indicated, "PLEASE TURN MY TV ON WHEN I AM IN BED.... Please provide me with social interactions and sensory stimulation twice a week. Allow me the opportunity to be socially and mentally engaged. Because of my medical condition I am unable to attend group programs. When you provide me with one on one programs be sure to incorporate topics that interest me. Some of those topics include hunting, fishing, sports, and family. I would like to go outside when the weather is nice. Please turn on my television when I am in bed...."</p> <p>The plan of care lacked documentation which specified what discipline was responsible for interventions to meet Resident 68's activity/psychosocial needs.</p> <p>During an interview on 8/8/2013 at 9:28 A.M., the Activity Director indicated Resident #68's care plan did not have goals that were measurable or with interventions assigned to specific disciplines to assure the interventions were being completed. The Activity Director was queried regarding who was responsible for interventions and how they were evaluated. The Activity Director stated, "There is no way to evaluate or to know who is responsible."</p>			

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	<p>During an interview on 8/8/2013 at 10:07 A.M., the Activity Director indicated Resident #68 still enjoyed any outdoor channel and she stated, "He absolutely loves hunting and fishing shows." The Activity Director indicated the TV should have been on when he was in his room but the activity staff most likely assumed the nursing staff was turning it on for him and the nursing staff most likely assumed the activity staff was turning it on for him. The Activity Director indicated she was not sure how it was determined two 1:1 activities a week were sufficient to meet Resident #68's needs.</p> <p>Review of a current facility care plan guideline policy dated 1/2008, provided by the Director of Healthcare Services on 8/9/2013 at 1:35 P.M., indicated, "Interdisciplinary team care plan guideline-Purpose: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines.... Each discipline shall be responsible for establishing a plan of care for acute problems as they occur.... New problem areas should be printed and added to the</p>						

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	existing care plans.... Resolved problem areas should be noted as resolved and placed in the resident's overflow file...." 3.1-35(a) 3.1-35(b)(1) 3.1-35(d)(2)(A)			

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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 allow a resident to participate in his plan of care related to a physician's appointment and failed to revise care plans in relation to foley catheter management and permanent resident placement for 3 of 30 residents reviewed for care planning. (Resident #5, #122, and #82)</p> <p>Findings included:</p> <p>1. Resident #122 was interviewed on 8/6/13 at 11:25 a.m. Resident #122 indicated he was not involved in the decisions about his daily care.</p>	F000280	Resident #122 has been reminded of all scheduled appointments and is involved in decisions of his daily care. Resident #122 schedules all his own appointments. Resident has been advised to make staff aware when he schedules appointments so we can keep record and remind him. Resident 1st meeting has occurred to determine areas resident does not feel he is aware of or involved in the decisions about his daily care. Findings from resident 1st conference will be added to residents care plan. Resident #5 is no longer a resident at the community as he went home on August 7, 2013 Resident #82's	09/11/2013	

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	<p>Resident #122 indicated the staff was not informing Resident #122 of his doctor appointments. Resident #122 indicated, "if I knew I had an appointment today, I would have scheduled another appointment while I was out." During this time, Resident #122 was observed informing LPN #23 of his lack of awareness regarding his appointment for that day. The LPN #23 informed the resident he was not aware of the resident's lack of awareness.</p> <p>Resident #122's record was reviewed on 8/8/13 at 11:30 a.m. The Resident's diagnosis included, but were not limited to, after care for joint replacement.</p> <p>Review of the Admission MDS (Minimum Data Set) Assessment 7/22/13, indicated the resident was cognitively intact.</p> <p>An interview with LPN #23 on 8/8/13 at 1:20 p.m., indicated the nursing staff manage the appointments and transportation for residents and would inform the residents and/or their families.</p> <p>2. Resident #5's record was reviewed on 8/7/13 at 1:20 p.m. Resident #5's diagnoses included, but were not</p>		<p>care plan has been updated to include her revised discharge plans. Resident #82's care plan has also been updated include psychosocial issues related to adjustment to the change with her discharge plans. A random audit of resident care plans has been conducted to assess appropriate interventions and measurable goals. Staff who document on care plans have been in-serviced on interventions with measurable goals. Random audits of 5 care plans will be conducted weekly by the DHS or designee for 90 days, and then monthly thereafter for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.</p>				

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	<p>limited to, transurethral resection of the prostate, benign prostatic hyperplasia, bladder stones, hematuria, and urinary retention.</p> <p>Review of an ER note dated 6/6/13, indicated the resident had the catheter placed by a urologist in May, 2013.</p> <p>Review of a consultation note dated 6/6/13, indicated the resident was seen on 5/28/13 by [Name of Physician's Office] for a voiding trial which was unsuccessful.</p> <p>Review of an Emergency Room note dated 7/24/13, indicated the resident had accidentally pulled out his foley catheter which contributed to penile bleeding and blockage.</p> <p>Review of the Bowel and Bladder care plan updated on 8/1/13, did not indicate measurable goals and interventions to prevent any further accidental removal of the foley catheter.</p> <p>An interview with the MDS (Minimum Data Set) Coordinator on 8/8/13 at 10:30 a.m., indicated the company had changed the care plans to an individualized computerized program. The MDS Coordinator indicated she</p>			

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	<p>will have to think of a way for goals and interventions to be measurable and specific.</p> <p>3. Resident #82's record was reviewed on 8/8/13 at 11:00 A.M. Resident #82 had diagnoses which included but were not limited to anxiety, depression.</p> <p>A care conference note, dated 7/10/13, indicated Resident #82's discharge plans had changed from a short term stay to a long term stay.</p> <p>Resident #82's current care plan, last revised on 7/11/13, lacked documentation which reflected the change in her discharge plans. The care plan lacked goals and/or interventions to address the psychosocial issues related to Resident #82's adjustment to the change with her discharge plans.</p> <p>During an interview on 8/8/13 at 11:50 A.M., the Director of Health Services (DHS) indicated the care plan had not been revised to reflect the change from a short term stay to a long term stay.</p> <p>3.1-35(c)(2)(C) 3.1-35(e)</p>						

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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 follow a written plan of care in which indicated residents would receive the minimal dosage of the prescribed psychotropic drug(s) for 1 of 5 residents reviewed for following plans of care (Resident #20).</p> <p>Findings include:</p> <p>Resident #20's record was reviewed on 8/7/13 at 9:00 A.M. Resident #20's diagnoses included, but were not limited to, hypertension, dementia, Alzheimer's disease and congestive heart failure.</p> <p>Review of the revised psychotropic drug care plan dated 5/26/13, indicated Resident #20 used psychotropic drugs for psychosis and anxiety. Goals listed included Resident #20 would receive minimal dosage of the prescribed psychotropic drug(s) to ensure maximum functional ability both mentally and physically. Interventions listed to meet this goal included the</p>	F000282	Resident #20 has had a gradual dose reduction (GDR) implemented for her Risperdal. All residents on psychotropic drugs will be assessed by Pharmacy Consultant, on September 4, 2013, for timely GDRs per state guidelines. Clinical Support will in-service the Pharmacy Consultant, Social Service Director, and Director of Health Services, September 4, 2013, on timeliness of GDRs per state guidelines. Pharmacy Consultant will audit residents on psychotropic drugs monthly for timely GDRs per state guidelines. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.	09/11/2013			

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	<p>facility would work with physician/pharmacy to provide the lowest therapeutic dosage.</p> <p>Resident #20 had a physician's order dated 5/11/2012, for Risperdal (anti-psychotic) 0.25 milligrams (mg) to be given every 12 hours for the diagnoses of psychosis.</p> <p>A GDRs was attempted on 8/1/2012. A physician's order dated 8/6/2012, indicated Resident #20 was restarted on the Risperdal at the same dose of 0.25 mg to be given every 12 hours.</p> <p>During an interview on 8/7/13 at 11:30 A.M., the Social Service Director (SSD) indicated a GDR had been attempted on 8-1-12. The SSD indicated the GDR failed and Resident #20 was restarted on Risperdal on 8-6-12 for behaviors. The SSD indicated no other GDRs had been attempted because the family did not want her medication changed. At this time, the SSD was asked to provide documentation of behaviors during the failed attempt of a GDR on 8/1/1012. The SSD indicated Resident 20's family was adamant about not changing her medications.</p> <p>A nurse's note dated 8/6/2013 at 1:30</p>						

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	<p>P.M., indicated Resident #20's physician was notified with a request to re-start the Risperdal 0.25 mg daily every 12 hours due to a failed reduction as evidenced by increased delusions. Documentation was lacking of what "delusions" Resident #20 was experiencing.</p> <p>A document titled, "Cor-Behavior Detail Report" indicated Resident #20 exhibited no behaviors during the Risperdal GDR attempt from 8-1-12 thru 8-6-12. The record lacked documentation of behaviors during the GDR trial period from 8/1/2012 through 8/5/2012.</p> <p>A pharmacist's note dated 8/7/13, indicated Resident #20 had been taking Risperdal since 2012. The note indicated GDRs were not attempted due to the request of Resident #20's family.</p> <p>3.1-35(g)(2)</p>				

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 observation, interview, and record review, the facility failed to ensure side rails/enablers dimensional limits for any open space within the perimeter of the rail measured less than 4 3/4 inches to prevent potential harm from entrapment for 1 of 15 residents observed with side rails/enablers (Resident #24).</p> <p>Findings include:</p> <p>Resident #24's record was reviewed on 8/9/2013 at 9:37 A.M. Resident #24 had diagnoses which included, but were not limited to, anxiety, hallucinations, muscle weakness, and pain. A quarterly minimum data assessment tool (MDS) dated 6/13/2013, indicated Resident #24 was a limited assist of one person for transfers and bed mobility.</p> <p>During an observation on 8/5/2013 at 10:21 A.M., Resident #24 was observed in bed. One side of the bed was positioned against the wall. The</p>	F000323	Resident #24's existing enabler has been removed. Resident has received a new bed with different type of enabler that meets state guidelines. All residents have been assessed for appropriate side rails. Staff have been in-serviced on appropriate side rail dimensions. Random audits will be conducted by the Director of Plant Operations or designee weekly for 90 days and then monthly for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.	09/11/2013			

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	<p>other side of the bed had an enabler which had a large open space within the perimeter of the device.</p> <p>During an observation on 8/5/2013 at 11:25 A.M., with the DHS (Director of Health Care Services), Resident #24's daughter, and the Executive Director (ED) present, the ED measured the area of the opening inside the perimeter of the enabler. The ED indicated the measurements were 10 inches by 35 inches. At this time the enabler was removed. All other side rails/enablers utilized in the facility were within the 4 3/4 inch measurements to prevent accidents.</p> <p>During an interview on 8/5/2013 at 11:25 A.M., Resident #24's daughter and the DHS indicated Resident #24 brought the enabler from home and it had been on her bed since July 2012. Resident #24's daughter indicated Resident #24 had used the enabler at home and during her stay at the facility without incident. She stated, "They never put it in right anyway. It is supposed to be pushed right up against the bed."</p> <p>An undated, current side rail use policy was provided by the ED on 8/9/2013 at 1:35 P.M. The policy indicated, "...To ensure the safe use</p>			

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	<p>of side rails as resident mobility aids.... When side rail usage is appropriate, the facility will assess the space between the mattress and side rails to reduce the risk for entrapment...." The policy lacked guidelines for appropriate measurements within the perimeter of the rail to ensure safety.</p> <p>3.1-45(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure residents who received anti-psychotic medications received gradual dose reductions (GDR) and were not given anti-psychotic medications without adequate indications for use for 1 of 5 residents reviewed for unnecessary medication use (Resident #20)</p> <p>Findings include:</p> <p>Resident #20's record was reviewed</p>	F000329	Resident #20 has had a gradual dose reduction (GDR) implemented for her Risperdal. All residents on psychotropic drugs will be assessed by Pharmacy Consultant, on September 4, 2013, for timely GDRs per state guidelines. Clinical Support will in-service the Pharmacy Consultant, Social Service Director, and Director of Health Services, September 4, 2013, on timeliness of GDRs per state guidelines. Pharmacy Consultant will audit residents on psychotropic drugs monthly for	09/11/2013

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	<p>on 8/7/13 at 9:00 A.M. Resident #20's diagnoses included, but were not limited to, hypertension, dementia, Alzheimer's disease and congestive heart failure.</p> <p>Resident #20 had a physician's order dated 5/11/2012, for Risperdal (anti-psychotic) 0.25 milligrams (mg) to be given every 12 hours for the diagnoses of psychosis.</p> <p>A GDR was attempted on 8/1/2012. A physician's order dated 8/6/2012, indicated Resident #20 was restarted on Risperdal at the same dose of 0.25 mg to be given every 12 hours. Documentation was lacking of an adequate indication for it's use.</p> <p>During an interview on 8/7/13 at 11:30 A.M., the Social Service Director (SSD) indicated a GDR had been attempted on 8-1-12. The SSD indicated the GDR failed and Resident #20 was restarted on Risperdal on 8-6-12 for behaviors. The SSD indicated no other GDRs had been attempted because the family did not want her medication changed. At this time, the SSD was asked to provide documentation of behaviors during the failed attempt of a GDR on 8/1/1012. The SSD indicated Resident 20's family was</p>		timely GDRs per state guidelines. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.		

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	<p>adamant about not changing her medications.</p> <p>A document titled, "Cor-Behavior Detail Report" indicated Resident #20 exhibited no behaviors during the GDR attempt from 8-1-12 thru 8-6-12. The record lacked documentation of behaviors during the GDR trial period from 8/1/2012 through 8/5/2012</p> <p>A nurse's note dated 8/6/2013 at 1:30 P.M., indicated Resident #20's physician was notified with a request to re-start the Risperdal 0.25 mg daily every 12 hours due to a failed reduction as evidenced by increased delusions. Documentation of what "delusions" Resident #20 was experiencing was lacking.</p> <p>A pharmacist's note dated 8/7/13, indicated Resident #20 had been taking Risperdal since 2012. The note indicated GDRs were not attempted due to the request of Resident #20's family.</p> <p>3.1-48(a)(2) 3.1-48(a)(4) 31.-48(b)(2)</p>				

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 15 residents observed during 6 medication pass observations. Two errors in 26 opportunities were observed during medication administration. This resulted in a medication error rate of 7.69%. (Residents #44, and #76)</p> <p>Findings included:</p> <p>1. During an observation on 8/7/13 at 8:30 a.m., LPN #22 removed Resident #76's Combivent inhaler (respiratory treatment) from the medication cart, entered the resident's room, gave instructions to the resident regarding the medication and administered one puff to the resident.</p> <p>Review of the Physician Recapitulation orders dated 7/31/13, indicated Combivent 18 mcg-103 mg inhalation aerosol, 2 puffs inhaled three times a day.</p> <p>An interview with LPN #22 on 8/8/13</p>	F000332	Resident #76 is no longer a resident at the community as she went home on August 15, 2013. LPN #23 has been in-serviced on rewriting a medication order to reflect medication interchange by pharmacy. Resident #44 has been receiving Optive Refresh correctly as prescribed. LPN #22 has been counseled in regards to correct administration of eye drops. Nurses have been in-serviced by the DHS/Designee on writing medication orders to reflect pharmacy interchange and on correct administration of eye drops. Random audit of medication orders to reflect pharmacy interchange and observation of eye drop administration, will be conducted weekly by the DHS or designee for 90 days, and then monthly thereafter for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.	09/11/2013	

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	<p>at 1:20 p.m., indicated there was an issue with the type of inhaler sent from the pharmacy and he would contact the physician for verification of orders.</p> <p>2. During an observation on 8/7/13 at 10:00 a.m., LPN #22 removed Resident #44's Optive Refresh eye drops from the medication cart, entered the resident's room, gave instructions to the resident regarding the medication and administered one drop to the inner corner of the resident's eye.</p> <p>An interview with LPN #22 on 8/8/13 at 9:15 a.m., indicated she was not aware she administered the eye drops incorrectly.</p> <p>Review of the Specific Medication Administration policy, dated 2/1/10, indicated "With a gloved finger, gently pull down lower eyelid to form 'pouch,' while instructing resident to look up...instill prescribed number of drops into 'pouch' near outer corner of eye...while the eye is closed, use one finger to compress the tear duct in the inner corner of the eye for 1-2 minutes..."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>				

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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 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 a date was recorded to indicate when eye drops were</p>	F000431	Resident #76 is no longer a resident at the community as she went home on August 15, 2013. LPN #22 has been in-serviced, by the DHS or designee, on	09/11/2013			

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	<p>opened, failed to ensure an insulin pen had not expired, and failed to ensure proper medication labels for 3 of 3 medication carts reviewed for drug storage. (Residents #36, #38, #76 and #117)</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 8/7/13 at 8:35 a.m., LPN #22 was observed administering Resident #76 Calcitonin nasal spray. The label indicated the spray was to be given in the evening. During this time, LPN #22 was interviewed and indicated the medication was to be given in the morning as ordered. Review of the August 2013 physician recapitulation orders on 8/7/13 at 4:00 p.m., indicated to administer the Calcitonin nasal spray upon arising. Review of the 300 Hall medication cart on 8/8/13 at 3:30 p.m., an insulin flexpen of Humalog insulin, belonging to Resident #117, was observed with a label to discard on 7/30/13. During this time, LPN #24 was interviewed and indicated the flex pen should had been discarded on 7/30/13. On 8/8/13 at 4:30 p.m., LPN #26 was observed to take out a box of Durezol 0.05% eye drops to 		<p>matching labels to physicians orders for consistency. Resident #117 is now receiving an insulin flexpen of Humalog that has not expired. LPN # 24 has been in-serviced, by the DHS or designee, on checking the expiration dates of labels prior to administration of drugs. Resident # 38 is now receiving Durezol 0.05% eye drops with an open date. LPN #26 has been in-serviced, by the DHS or designee, on checking for open dates prior to drug administration. Resident #36 is no longer a resident at the community as she went home on August 12, 2013. LPN #24 has been in-serviced on when their is a change in Coumadin, sending the discontinued dose back to pharmacy and ordering new dose to be delivered. All medications have been recorded with a date of when they were opened. All insulin pens have been checked for expiration dates. All medications have been checked for proper medication labels. All nurses have been in-serviced by the DHS or designee, on when there is a change in Coumadin sending the discontinued dose back to pharmacy and ordering new dose to be delivered. Random audits of; matching labels to physicians orders for consistency, checking the expiration dates of labels, checking for open dates prior to drug administration, and changes</p>				

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	<p>administer to Resident #38. Upon review of the box and bottle, there were no open date observed. During this time, LPN #26 was interviewed and indicated there should have been an open date and she did not know when the medication was opened.</p> <p>4. On 8/8/13 at 5:00 p.m., LPN #24 was observed administering coumadin (blood thinner) 1 mg (milligram) to Resident #36. The label indicated 1 mg qod (every other day) alternating with 2 mg qod. LPN #24 indicated the order had changed to 1 mg for two days alternating 2 mg on the third day.</p> <p>Review of the physician orders, dated 8/5/13 on 8/8/13 at 10:00 a.m., indicated coumadin was to be given 1 mg for two days and alternating 2 mg on the third day.</p> <p>Policies regarding medication labels and expired medications were requested but not given.</p> <p>3.1-25(j) 3.1-25(k)(5)(6)</p>		<p>in Coumadin, will be conducted weekly by the DHS or designee for 90 days, and then monthly thereafter by the Consultant Pharmacist for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.</p>		

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review and interview, the facility failed to</p>	F000441	Resident #44 is now receiving eye drops from a nurse wearing	09/11/2013			

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	<p>ensure infection control was maintained during medication administration for 3 of 6 opportunities observed. (Resident #44, #26, and #123).</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During a medication observation on 8/7/13 at 10:00 a.m., LPN #22 removed Resident #44's Optive Refresh eye drops from the medication cart, entered the resident's room, gave instructions to the resident regarding the medication and administered the resident's eye drops without wearing gloves. 2. During a medication observation on 8/7/13 at 11:55 a.m., LPN #22 was observed administering insulin into Resident #26's abdomen without wearing gloves. 3. During a medication observation on 8/7/13 at 12:05 p.m., LPN #25 was observed removing a stethoscope from around her neck and placing it on Resident #123's abdomen without cleaning before placement. After placement verification was completed, LPN #25 placed the stethoscope back around her neck without cleaning it. Upon completion of the medication administration, LPN 		<p>gloves. LPN #22 has been counseled on the importance of wear gloves during eye drop administration Resident #26 is now receiving insulin from a nurse wearing gloves. LPN #22 has been in-serviced on the importance of wear gloves during insulin administration Resident #123 is no longer a resident at the community as he went home on August 26, 2013. LPN # 25 has been in-serviced on the importance of cleaning the stethoscope prior to and after each use. Nurses have been in-serviced by the DHS or designee on the importance of wearing gloves during eye drop administration, wearing gloves during insulin administration, and cleaning the stethoscope prior to and after each use. Random audits of eye drop administration, insulin administration, and stethoscope cleaning will be conducted weekly by the DHS or designee for 90 days, and then monthly thereafter for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.</p>		

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	<p>#25 washed her hands and return to the medication cart and placed the stethoscope in the center of the medication cart without cleaning after use on Resident #123. During this time, LPN #25 was interviewed and she had indicated the stethoscope belonged to the facility and one was stored on each medication cart. LPN #25 indicated she had not cleaned the stethoscope since early in the morning.</p> <p>An interview with LPN #22 on 8/8/13 at 9:15 a.m., acknowledged gloves should have been worn with the eye drop and insulin administration.</p> <p>The Specific Medication Administration policy for Eye Drop, Intramuscular Medication and Enteral Tube Medication Administration dated 2/1/10, was provided by the Company's Nursing Consultant on 8/8/13 at 12:20 p.m. The policies indicated examination gloves were to be worn when administering eye drops and intramuscular administration. There was lack of documentation in the enteral tube medication administration policy indicating to clean equipment before and after use on a resident. During this time, the Nursing Consultant was interviewed and indicated the</p>				

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	<p>company did not have a policy on cleaning equipment used on residents and did not have a specific policy for subcutaneous/insulin administration. The Nursing Consultant recommended to use the Intramuscular Administration policy for insulin administration.</p> <p>3.1-18(j)</p>				

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R000000	<p>This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.</p> <p>Survey dates: August 5, 6, 7, 8, and 9, 2013</p> <p>Facility number: 002703 Provider number: 155680 AIM number: 200309250</p> <p>Survey team: Lora Brettnacher, RN, TC Jeanna King, RN Karen Hartman, RN Shannon Pietraszewski, RN</p> <p>Census bed type: SNF: 24 SNF/NF: 35 Residential: 34 Total: 93</p> <p>Census payor type: Medicare: 18 Medicaid: 23 Other: 52 Total: 93</p> <p>Residential sample: 7</p> <p>The following Residential deficiencies</p>	R000000	<p>The submission of this Plan of Correction does not indicate an admission by Homewood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Homewood Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p>	
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	<p>were cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 08/19/2013 by Brenda Marshall Nunan RN.</p>				

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R000026	<p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on observation and interview, the facility failed to post a copy of residents' rights in a publicly accessible area in the locked memory care unit. This deficient practice had the potential to affect 13 of 13 residents who resided on the locked memory care unit.</p> <p>Findings include:</p> <p>During observations on the facility's locked memory care unit on 8/9/2013 at 11:40 A.M., a copy of residents' rights was not observed.</p>	R000026	Resident Rights has now been posted in the secured unit Residents and staff have been in-serviced by the ED or designee on the location of the Residents Rights Posting. Audit of secured unit Resident rights posting will be conducted by the Executive Director weekly for 90 days and monthly thereafter for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.	09/11/2013	

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	<p>During an interview on 8/9/2013 at 11:50 A.M., the Memory Care Coordinator indicated resident rights information was not posted in the locked unit.</p> <p>16.2-5-1.2(h)(2)</p>			

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R000033	<p>410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area accessible to residents and updated as appropriate. Based on observation and interview, the facility failed to post information which informed residents how to file a complaint and/or information for contacting advocacy agencies. This deficient practice had the potential to affect 13 of 13 residents who resided on the locked memory care unit.</p> <p>Findings include:</p> <p>During observations on the facility's locked memory care unit on 8/9/2013 at 11:40 A.M., information on how to file a complaint and/or advocacy</p>	R000033	Information on how to file a complaint and or advocacy contact information has now been posted in the secured unit Residents and staff have been in-serviced by the ED or designee on the location of the Information on how to file a complaint and or advocacy contact information. Audit of secured unit Information on how to file a complaint and or advocacy contact information posting will be conducted by the Executive Director weekly for 90 days and monthly thereafter for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings	09/11/2013
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	<p>contact information were not observed.</p> <p>During an interview on 8/9/2013 at 11:50 A.M., the Memory Care Coordinator indicated information on how to file a complaint and/or agency contact addresses and phone numbers were not posted in the locked unit.</p> <p>16.2-5-1.2(h)(2)</p>		monthly for 6 months.		

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R000042	<p>410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and interview, the facility failed to provide the results of the most recent annual survey conducted by the state surveyors. This deficient practice had the potential to affect 13 of 13 residents who resided on the locked memory care unit.</p> <p>Findings include:</p> <p>During observations on the facility's locked memory care unit on 8/9/2013 at 11:40 A.M., the results of the most recent survey were not observed.</p> <p>During an interview on 8/9/2013 at 11:50 A.M., the Memory Care Coordinator indicated the results of the most recent survey were not available for residents residing in the memory care locked unit.</p> <p>16.2-5-1.2(p)</p>	R000042	The results of the most recent survey have now been posted in the secured unit Residents and staff have been in-serviced by the ED or designee on the location of the results of the most recent survey. Audit on secured unit of results of the most recent survey posting will be conducted by the Executive Director weekly for 90 days and monthly thereafter for a total of 6 months. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.	09/11/2013	

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R000052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure residents were free of physical abuse for 1 of 1 residents reviewed for abuse (Resident #10).</p> <p>Findings include:</p> <p>Resident #10's record was reviewed on 8/9/2013 at 12:00 P.M. Resident #10 had diagnoses which included, but were not limited to, depression, hypertension, Alzheimer's disease, and diabetes.</p> <p>Review of a social service note dated 2/11/2013, indicated, "Writer notified of abuse allegation and went to speak with [Resident #10 named] 1:1. [Resident #10 named] when asked how her care was, she very clearly stated, 'She poured water on me.'" Writer asked "Who poured water on you?" [Resident #10 named] responded, "The girl poured water on me because I was sleeping at the dinner table." Writer thanked</p>	R000052	Resident #10 is free of physical abuse. CRMA #51 is no longer employed with community. Employees have been in-serviced by the ED or designee on the policy for Abuse Prohibition. Random audit of residents, by the Social Services Director, will be conducted weekly for 90 days and monthly thereafter for a total of 6 months, to determine if abuse has occurred. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 6 months.	09/11/2013	

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	<p>[Resident #10 named] for telling writer about incident, gave her a hug and apologized reassuring her that that kind of behavior would not be tolerated and that the DHS [Director of Health Care Services] is aware of the situation and taking appropriate measure to ensure nothing happens like this again. [Resident #10 named] thanked writer. When writer asked [Resident #10 named] if she feels safe, she responded "I did. Now I don't know what to expect..."</p> <p>During an interview on 8/9/13 at 2:10 P.M., Certified Resident Medication Aide(CRMA) #51 indicated on February 7, 2013 [Thursday] Resident #10 had her head down on the dining room table and she witnessed (CRMA) #52 flip water on the back of Resident #10's neck. CRMA #51 indicated Housekeeper #53 witnessed it as well. CRMA #51 indicated she did not report the incident to anyone because she did not feel it was abuse. It wasn't until the following Monday [February 11, 2013] when Housekeeper #53 reported the incident.</p> <p>During an interview on 8/9/13 at 2:30 P.M., Resident #10 indicated she was resting her head on the dining room table when "she" flipped water on her.</p>			

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	<p>Resident #10 stated, "It was cold and it made me mad."</p> <p>During an interview on 8/9/2013 at 3:05 P.M., the DHS (Director of Health Services) indicated, after the incident occurred, CRMA #52 worked all weekend on the Memory Care Unit where Resident #10 resided. The DHS indicated she was not informed of the incident until Monday morning, at which time, CRMA #52 was terminated.</p> <p>The facility's current policy for Abuse Prohibition dated 9/16/2011, provided by the Executive Director on 8/9/2013 at 1:30 P.M., was reviewed. The policy indicated, "Trilogy Health Services (THS), LLC-Abuse and Neglect procedural Guidelines-Purpose: ... has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect.... THS has implemented processes in an effort to provide a comfortable and safe environment... The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures.... Definitions: ABUSE means the willful infliction of...</p>				

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	<p>intimidation, or punishment resulting in physical harm, pain, or mental, or psychosocial well-being. This presumes the instances of abuse of all residents, even those in a coma, cause physical harm, or pain, and mental anguish.... Identification... Any person, with knowledge or suspicion of suspected violations shall report immediately.... The Shift Supervisor or Manager is identified as responsible for initiating and/or continuing the reporting process, as follows: IMMEDIATELY notify the Executive Director.... Protection-Upon identification of suspected abuse or neglect, immediately provide for the safety of the resident.... Suspend suspected employee(s) pending outcome of investigation...."</p> <p>16.2-5-1.2(v)(2)</p>				

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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to attempt to hold fire and disaster drills in conjunction with the local fire department. This deficient practice had the potential to affect 93 of 93 residents residing in the facility.</p> <p>Findings include:</p> <p>The facility's fire drill records from January 2013 thru August 2013, were</p>	R000092	Fire and disaster drills are now being held every 6 months in conjunction with the local fire department. Maintenance department has been in-serviced by the ED or designee on the importance of making sure fire and disaster drills are now being held every 6 months in conjunction with the local fire department. Audit of monthly fire drills will be conducted by the ED or designee to ensure that every 6 months a fire and disaster drill is being held in conjunction with	09/11/2013			

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	<p>reviewed on 8/9/2013 at 10:00 A.M. Documentation was lacking which indicated attempts to hold fire and disaster drills in conjunction with the local fire department.</p> <p>During an interview on 8/9/2013 at 10:15 A.M., the Maintenance Supervisor indicated he began employment with the facility in March 2013. He had not attempted to hold fire and/or disaster drills in conjunction with the local fire department since he had been there. The Maintenance Supervisor indicated he could not find documentation which indicated it had been done in January or February of 2013. He indicated he was not aware of the regulation which required attempts to be made every six months.</p> <p>16.2-5-1.3(i)(2)</p>		the local fire department. Findings of the audits will be reviewed at the Quality Assurance Meetings monthly for 1 year.		