

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155247	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2012
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November, 13th, 14th, 15th, 16th, 19th, and 20th, 2012</p> <p>Facility number: 000151 Provider number: 155247 AIM number: 100284060</p> <p>Survey team: Beth Walsh, RN-TC Courtney Mujic, RN Karina Gates, Medical Surveyor</p> <p>Census bed type: SNF: 42 SNF/NF: 82 Total: 124</p> <p>Census payor type: Medicare: 28 Medicaid: 63 Other: 33 Total: 124</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/28/12 Cathy Emswiller RN</p>	F0000	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date indicated.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on record review, observation, and interview the facility failed to ensure a resident's privacy and dignity were maintained for 1 of 23 residents interviewed in stage 1 of the survey. The facility also failed to let a resident remain sleeping her bed during a random observation. (Resident #138 and #166).</p> <p>Findings included:</p> <p>1. Resident #138's clinical record was reviewed on 11/19/2012 at 10 a.m. Diagnoses included but were not limited to; dementia, and congestive heart failure.</p> <p>On 11/13/2012 at 2:45 pm, CNA #5 and Floor technician #6 walked into the Resident #138's room while the resident was participating in a confidential interview. The facility staff failed to knock first and request permission to enter the room.</p> <p>The Administrator was interviewed on 11/20/2012 at 1:14 pm and indicated</p>	F0241	<p>F 241 It is the practice of Manor Care Indy South to provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? Staff are now knocking first and requesting permission to enter Resident #138's room. Resident #166 was not harmed by the C.N.A. attempts to arouse. C.N.A. #5 and Floor Technician #6 were given a 1:1 education on the importance of resident's right to privacy and respect. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents who reside in facility are at risk and have the potential to be affected. We will continue to provide care for residents in a manner and in an environment that maintains or enhances each resident's dignity, respect, and privacy. What measures will be</p>	12/20/2012

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	<p>the expectation is that staff members knock on doors before entering a resident's room.</p> <p>2. During a random observation on 11/19/12 at 1:36 p.m., Resident #166 was observed sleeping, in her bed. CNA #7 shook Resident #166's arm and, in a firm voice, called Resident #166's name. Resident #166 did not respond and remained asleep. CNA #7 shook Resident #166's arm more vigorously and called her name more loudly. Resident #166 sprung up in surprise and looked around. CNA #7</p>		<p>put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Facility staff will be in-serviced on the provision of care and services respecting the resident's right to dignity, respect, privacy. How the corrective action will be monitored to ensure the deficient practice does not reoccur? Facility department heads, including nursing leadership together will conduct a total of 25 random observations of staff's interactions with residents weekly times 4 weeks, then monthly times 4 months to assure care is dignified, respectful, and privacy is maintained. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee weekly. Date to be completed 12/20/2012</p>	

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	<p>asked Resident #166 if she needed anything. Resident #166 stated, "No. I'm just taking a little cat nap." CNA #7 proceeded to put mats down on either side of her bed and lowered the bed. Resident #166 lay back down and closed her eyes.</p> <p>3.1-3(t)</p>			

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F0246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on record review and interview the facility failed to consider individual preference in providing showers to a resident for 1 of 3 residents reviewed for choices. Resident #138.</p> <p>Findings included:</p> <p>An interview with the D.O.N. on 11/19/2012 at 11:25 am indicated the admitting nurse tells the resident what their shower days are and if the resident wants something different they would tell the nurse at that point.</p> <p>An interview with LPN #9 on 11/19/2012 at 11:43 am indicated when she admits brand new residents to the unit she tells them when their shower days/shifts are. Everyone is assigned a shower according their room number. If someone told us they had a problem with it, it would be a special circumstance but we would accommodate them.</p> <p>An interview on 11/13/2012 at 2:22</p>	F0246	<p>F 246 It is the practice of Manor Care Indy South to provide our residents with reasonable accommodations of individual needs and preferences. What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? Resident #138 has been re-interviewed and we are meeting her specific choices and preferences related to how and when she is assisted with her ADL needs. Care plan has been updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents that reside in the facility are at risk and have the potential to be affected. Each resident will be interviewed to assure choices and preferences for ADL care needs have been identified and care planned. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p>	12/20/2012	

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	<p>pm with Resident #138 indicated the following in response to the question, "Do you choose how many times a week you take a bath or shower?" The resident indicated, "No. Wednesdays and Saturdays are (her) shower days, (she) would like to take one every day but there isn't enough help for that."</p> <p>A care plan indicated, dated 9/26/12, "Focus: (Resident's name) needs assistance from staff at times for her ADL self care deficit as evidenced by: disease process dementia, congestive heart failure. Goals: Will participate in self-care tasks at the highest practicable level of functioning. Will be clean, dressed, and well groomed daily to promote dignity and psychosocial well being. Interventions: Assist to bathe/shower as needed."</p> <p>An interview with Resident #138 on 11/20/2012 at 9:22 am indicated she has asked staff (though she can't remember specifically who) if she could have a shower more than two times a week and their response was, 'no, we are too understaffed.' The resident felt there aren't enough nurses aides because 'they barely have time to give anyone a bath even when they are scheduled.'</p>		<p>Facility staffs will be in-serviced on the following: Ø Dignified care and needs accommodation Ø A Resident's right to choose How the corrective action will be monitored to ensure the deficient practice does not reoccur? Facility department heads, including nursing leadership together will conduct a total of 25 random observations of staff's interactions with residents weekly times 4 weeks, then monthly times 4 months to assure care and services are accommodated and completed according to resident's preferences and choices. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee weekly. Date to be completed 12/20/2012</p>				

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	<p>A shower list for A wing (where Resident #138 resides) was provided on 11/20/2012 at 1:05 pm by the Assistant Director of Nursing. The shower list indicated the shower days and shifts for each resident bed. The shower schedule for Resident #138 indicated Wednesday on day shift, and Saturday on day shift. The shower list also indicated, "No changes made until after confirming with manager!"</p> <p>3.1-3(v)(1)</p>			

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F0278 SS=D	<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 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 observation, interview, and record review, the facility failed to correctly code answers on the MDS (Minimum Data Set) assessment for 1 of 3 residents reviewed for urinary incontinence and for 1 of 3 residents reviewed for dental status. (Resident #205 and #24)</p>	F0278	F 278 It is the practice of Manor Care Indy South to complete assessments that accurately reflect the resident's status. What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? MDS correction will be submitted for Resident #205 with	12/20/2012

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	<p>Findings include:</p> <p>1. The clinical record for Resident #205 was reviewed on 11/19/12 at 11:55 a.m. The diagnoses for Resident #205 included, but was not limited to: benign prostatic hyperplasia.</p> <p>A review of the October Physician's Orders indicated a #16 French Foley catheter with a 30 milliliter bulb was ordered. There was no further orders to discontinue the Foley catheter after the October Physician's Orders, in the clinical record.</p> <p>The Admission MDS, dated 7/13/12, indicated Resident #205 had an indwelling catheter.</p> <p>The Quarterly MDS, dated 10/9/12, indicated Resident #205 did not have an indwelling catheter and was occasionally incontinent.</p> <p>In an interview with the MDS Coordinator, on 11/19/12 at 2:55 p.m., the MDS Coordinator indicated she incorrectly coded the 10/9/12 MDS and the MDS should've have indicated there was an indwelling catheter in place for the Resident.</p>		<p>ARD 10/9/12. Resident #205's current condition related to continence was assessed and care plan updated as necessary. MDS correction will be submitted for Resident #24 with ARD 10/24/12. Resident #24's current dental condition was assessed, care plan updated as necessary. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents with MD orders for urinary catheters and residents with identified dental concerns, including missing, broken, or loose teeth are at risk and have the potential to be affected. Last submitted MDS will be reviewed for accuracy based on documentation in clinical record at the time of the reference period for residents with orders for urinary catheters and residents with dental concerns. MDS correction will be submitted if inconsistencies are noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? MDS Coordinators will be in-serviced on interview process accuracy and congruency. How the corrective action will be monitored to ensure the deficient practice does not reoccur? MDS Coordinator for each MDS</p>	

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	<p>2. The clinical record for Resident #24 was reviewed on 11/19/12 at 1:00 p.m.</p> <p>The diagnoses for Resident #24 included, but were not limited to: diabetes and dementia.</p> <p>An observation of Resident #24's teeth were made on 11/15/12 at 1:26 p.m. Several teeth were missing. One appeared broken, and several were discolored and rotten.</p> <p>The 10/22/12 significant change MDS (minimum data set) assessment indicated Resident #24 did not have any obvious or likely cavity or broken teeth.</p> <p>During an interview with the MDS Coordinator #2 on 11/20/12 at 11:52 a.m. regarding how the dental section of the MDS assessment is completed, she indicated the resident's mouth is actually observed. She also indicated she, herself, did Resident #24's 10/22/12 significant change MDS assessment.</p> <p>An observation with MDS Coordinator #2 of Resident #24's oral cavity was made on 11/20/12 at 12:05 p.m. Several teeth were observed missing</p>		<p>assessment will review continence and dental status and interview resident to assure accuracy of MDS coding. Prior to final submissions, MDS Coordinator will report to ADNS findings that support congruency and accuracy. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee weekly. Date to be completed 12/20/2012</p>				

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	<p>on top and all teeth present were discolored and rotten. Resident #24 stated, "I don't know how many I have in there." After the observation, MDS Coordinator #2 indicated, "I can see that I coded that wrong. It should say missing, broken, obvious cavity."</p> <p>3.1-31(d)</p>			

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F0279 SS=D	<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 observation, interview, and record review, the facility failed to develop a nutritional care plan that was triggered by the MDS (Minimum Data Set) assessment, for 1 of 3 residents reviewed for nutrition. The facility also failed to develop a plan of care to reflect dressing her in a hospital gown daily for 1 of 3 residents reviewed for dignity. (Resident #220 and #2)</p> <p>Findings include:</p> <p>1. The clinical record for Resident</p>	F0279	<p>F 279 It is the practice of Manor Care Indy South to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? Nutritional care plan for Resident #220 was developed based on assessed needs. Resident #2's care plan has been update to reflect choices and preferences for ADL care and dressing needs. C.N.A.#7 and L.P.N.#8 received 1:1 education related to</p>	12/20/2012

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	<p>#220 was reviewed on 11/16/12 at 1:30 p.m. The diagnoses for Resident #220 included, but were not limited to: urinary obstruction, kidney disease, presenile dementia, and dementia with behaviors. Resident #220 was initially admitted on 9/13/12 and readmitted on 10/17/12.</p> <p>The care plans reviewed for Resident # included, but were not limited to:cognitive loss, dated 11/9/12, use of indwelling urinary catheter, dated 10/18/12, potential for discharge, dated 11/9/12, at risk for mood changes, dated 11/9/12, and risk for falls, dated 10/18/12. A nutritional care plan was not located in the clinical record.</p> <p>During an interview with the DoN (Director of Nursing), on 11/16/12 at 12:48 p.m., the DoN indicated all care plans were located in the clinical record.</p> <p>A review of the 9/20/12 Admission MDS (Minimum Data Set) indicated a nutritional care area was triggered and was addressed in a care plan.</p> <p>During an interview with the Registered Dietician, on 11/16/12 at 2:00 p.m., she indicated she made all the nutritional care plans. She</p>		<p>respecting resident and family choices. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents who reside in facility are at risk and have the potential to be affected. Medical Record of residents who triggered for nutritional care plans on the most recent MDS have been reviewed to assure a care plan was initiated as triggered. Medical Record of residents who have specific preferences for dressing and grooming have been reviewed to assure an ADL care plan reflected those preferences. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? MDS Coordinator will be educated to validate the following: When an IDT member, completes a care area assessment and decides to proceed to care plan, MDS Coordinator will ensure the care plan is in place. Facility staff will be in serviced on Resident's right to choose. How the corrective action will be monitored to ensure the deficient practice does not reoccur? MDS Coordinator will report MDS triggered items in morning clinical meeting with IDT. ADNS or designee will review triggers for</p>				

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	<p>determined when a care plan needed to be created, for example, when the care plan was triggered by a MDS, a resident had a significant weight loss, or a resident had a feeding tube.</p> <p>A care plan with a focus of nutritional status as evidenced by potential weight loss related to inadequate oral intake, swallowing difficulty, involuntary weight loss, and therapeutic diet, was received from the Registered Dietician (RD), at 2:15 p.m. on 11/16/12. The RD indicated at this time that she just created the nutritional care plan, though she intended to make the care plan the previous day.</p> <p>During an interview with the MDS Coordinator, on 11/19/12 at 10:30 a.m., she indicated the previous Admission MDS, dated 9/20/12, was still relevant for what care areas were triggered, even though the Resident was readmitted.</p> <p>2. Resident #2's clinical record was reviewed on 11/16/2012 at 2:00 pm. Diagnoses included but not limited to; Epilepsy, aphasia, and persistent vegetative state.</p> <p>Staff dressed resident in institutional fashion such as a hospital type gown during the day as observed by the</p>		<p>nutritional care planning and validate that a care plan is initiated as triggered. IDT will complete random questionnaires of residents to assure their choices are identified and honored. Team will complete 10 resident questionnaires weekly and report finding in the morning clinical meeting with IDT. Care plans will be update as necessary. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee weekly. Date to be completed 12/20/2012</p>		

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	<p>resident wearing a hospital gown while laying in bed on the following days and times; 11/15/2012 at 10:37 am, 11/16/2012 at 1:30 pm, and 11/19/2012 at 2:09 pm.</p> <p>A care plan, revised 6/26/2009, indicated, "Focus: Dependable [sic] on staff for ADL's (activities of daily living) r/t (related to) Persistent Vegetative [sic] state. Goals: Will remain comfortable and w/o (without) complication of dependant care."</p> <p>Resident #2's care plans were reviewed and no mention of wearing a hospital gown daily could be found in any of the resident's care plans.</p> <p>An interview on 11/20/2012 at 10:47 am with CNA #7 and LPN #8 indicated the resident had house coats brought in by her mother, who would like the resident to wear these backwards. The house coats were the kind that button all the way down. However, the nursing staff feels that this restricts the resident's arm movement and then the resident gets frustrated that she can't move. CNA #7 indicated she only puts the house coats on the resident when the mother comes to visit, otherwise she dresses her daily in a new hospital gown provided by the facility. When</p>			

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	<p>asked if the dress house coat could be put on frontward and whether or not this would restrict her movement as well the CNA #7 indicated she would think so, because the resident has contractures that limit her movement.</p> <p>3.1-35(a)</p>			

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F0280 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 observation, interview, and record review, the facility failed to revise a care plan for fall risk for 1 of 3 reviewed for falls. The facility also failed to comprehensively assess and update a plan of care to reflect a resident's urinary continence status for 1 of 3 residents reviewed for urinary incontinence. (Resident #121 and Resident #100)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #100 was reviewed on 11/16/12 at 11:45 a.m. The diagnoses for Resident #100 included, but were not</p>	F0280	<p>F 280 It is the practice of Manor Care Indy South to honor the resident's right to participate in planning care and treatment or changes in care and treatment. What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? A comprehensive urinary assessment was completed with revision to care plan for Resident #121. Resident #100 no longer has need for bed/chair alarm, MD order was discontinued, care plan intervention was revised. How other residents having the potential to be affected by the same deficient practice will be</p>	12/20/2012			

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	<p>limited to: hypertension, diabetes mellitus, and cerebrovascular disease.</p> <p>A review of the care plan for fall risk, dated 9/27/12, indicated one of the interventions to be utilized was a bed alarm on, when Resident #100 was in bed.</p> <p>During an observation of Resident #100 in bed, on 11/16/12 at 12:40 p.m., no bed alarm was noted to be on.</p> <p>A Physician Order, dated 11/6/12, indicated the bed/chair alarm was to be discontinued due to resident refusal.</p> <p>During an interview with the DoN (Director of Nursing), on 11/16/12 at 12:48 p.m., she indicated Unit Managers review Physician's Orders daily and update care plans a day after a new Physician's Order was written.</p>		<p>identified and what corrective action will be taken? Residents who have a change in urinary continence based on MDS coding are at risk and have the potential to be affected by this deficient practice. These residents will be identified, assessed and care plans will be update to reflect current status. Residents who have orders for bed/chair alarm are at risk and have the potential to be affected by this deficient practice. These residents will be identified, care plan reviewed to assure fall alarms are care planned as ordered. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? MDS Coordinators and Licensed Nursing staffs will be in-serviced on the following: Ø Updating a resident's care plan after a change in a resident's condition or status and Urinary Continence Practice Guide How the corrective action will be monitored to ensure the deficient practice does not reoccur? ADNS or designee will monitor weekly during the morning clinical meeting physician orders, changes in a resident's urinary continence and fall alarm device orders to assure the resident's current orders are reflected in the plan of care. ADNS or designee will also assure through weekly monitoring</p>	

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	<p>2. Resident #121's clinical record was reviewed on 11/16/2012 at 1:30 pm. Diagnoses included but not limited to; chronic obstructive pulmonary disease, sepsis, hypertension, acid reflux, pneumonia, diabetes, and urinary tract infection.</p> <p>An admission MDS assessment completed on 6/29/2012 indicated, "Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding.)"</p> <p>A quarterly review MDS assessment completed on 9/21/2012 indicated, "Always incontinent (no episodes of continent voiding.)"</p> <p>A care plan indicated, "Revision date: 9/12/12. Focus: urinary incontinence r/t (related to) pressure ulcers, BPH (enlarged prostate), and immobility. Goal: minimize complications d/t (due</p>		<p>that residents with acute changes in continence status, are assessed per our policy. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee weekly. Date to be completed 12/20/2012</p>	

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	<p>to) incontinence. Interventions: apply skin moisturizers/barrier creams as needed. Place urinal/bedpan within resident's reach. Provide assistance with toileting. Provide incontinent care as needed. Report changes in skin integrity found during daily care. Report s & s (signs and symptoms) of UTI (urinary tract infection) such as flank pain, c/o (complaints of) burning/pain, fever, hematuria (blood in urine), change in mental status, etc. Therapy evaluation and treatment as ordered. Administer medication per physician's orders."</p> <p>An interview with the D.O.N. and Nurse Consultant on 11/20/2012 at 12:40 pm indicated they cannot prove they fully assessed the resident for incontinence. There is a form found in Resident #121's clinical record but there is no date listed, so it appeared that he was assessed but the staff never followed through with putting in place a bladder training program, and they didn't update the care plan. They are currently in transition. The old way they did things was focused more on determining what times the resident was experiencing incontinence. The new way is more comprehensive, it follows the flowchart. This is how they are going to put into place the new system currently and in the future.</p>			

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	<p>A 'Urinary Incontinence Practice Guide Flowchart' was provided by the D.O.N. on 11/20/2012 at 12:35 pm indicated, "Assessment -> Complete Patient Admission/Readmission Screen -> Does patient have history/evidence of incontinence? No -> Monitor for change in status. Yes -> Initiate bladder diary -> Complete Urinary incontinence evaluation -> Develop/Review Interim or Interdisciplinary care plan, toileting program as appropriate -> Initiate/Update patient information worksheet, Kardex, task list -> Implement -> Ongoing management strategies: Patient/Family education: Staff education -> Evaluate."</p> <p>3.1-35(d)(2)(B)</p>			

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F0282 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 physician's orders for 1 of 3 residents reviewed for urinary catheter use. (Resident #220)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #220 was reviewed on 11/16/12 at 1:30 p.m. The diagnoses for Resident #220 included, but were not limited to: recent history of septic shock/urinary tract infection, urinary obstruction, kidney disease, presenile dementia, and dementia with behaviors. Resident #220 was admitted on 9/13/12 and readmitted on 10/17/12.</p> <p>A Physician's Order, dated 10/18/12 at 11:30 a.m., indicated a follow-up with Dr. (Name of Medical Doctor) in 1 week for use of an indwelling catheter.</p> <p>An appointment date or visit summary, for the above Physician's Order, was not located in the clinical</p>	F0282	<p>F 282 It is the practice of Manor Care Indy South to provide or arrange services by qualified persons in accordance with each resident's written plan of care. What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? Resident #220 Urologist was contacted and orders were given to discontinue the catheter. Labs were reviewed by Nurse Practitioner, no concerns identified with H&H results. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents who reside in this facility and have physician orders for outside appointments, labs, diagnostics are at risk and have the potential to be affected by this deficient practice. Lab tracking system and system for appointment scheduling is now in place for all labs, diagnostics, and outside consultant physician appointments. What measures will be put into place or what systemic changes will be made to ensure that the deficient</p>	12/20/2012	

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	<p>record and was requested on 11/19/12 at 1:00 p.m.</p> <p>During an interview with Consultant #3, on 11/19/12 at 2:30 p.m., she indicated she nor the DoN (Director of Nursing) was able to locate an appointment date/time or a review of the visit with the above Medical Doctor (MD). She also indicated the Facility called the above MD office and the MD office indicated Resident #220 had not had a scheduled appointment/visit since before Resident #220 was admitted to the Facility in September. Consultant #3 indicated the appointment should've been scheduled and she did not know why it wasn't.</p> <p>2. A review of a Physician's Order for Resident #220, dated 10/23/12 (no time noted), indicated a weekly CBC (complete blood count-blood test) and BMP (basic metabolic panel-blood test) should have been drawn weekly for 4 weeks.</p> <p>The CBCs were not located in the clinical record and were requested on 11/19/12 at 1:00.</p> <p>During an interview with Consultant #3, on 11/19/12 at 2:20 p.m., she indicated the Nurse Practitioner just</p>		<p>practice does not reoccur? Licensed nursing staffs will be in-serviced on the following: Ø MD order transcription; 24 Hour Chart Check Process Ø Appointment Scheduling Process Ø Lab monitoring procedure How the corrective action will be monitored to ensure the deficient practice does not reoccur? ADNS or designee will monitor daily MD orders for labs and appointments to assure labs as ordered are drawn, outside appointments are scheduled, notification, results are documented in clinical record. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. Date to be completed 12/20/2012</p>		

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	<p>clarified the above order. The Physician's Order, dated 11/19/12, no time noted, indicated to clarify the order for 10/23/12, H and H (hemoglobin/hematuria) should be drawn every week for 4 weeks, and to discontinue the CBC. When asked why the order wasn't clarified till it was brought to the Facility's attention, the Consultant indicated she was unsure why the order wasn't clarified till that day.</p> <p>At 11:21 a.m., on 11/20/12, the DoN (Director of Nursing) indicated all nursing staff was to follow all physician's orders as written</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 observation, interview, and record review, the facility failed to address a resident's bruising upon recognition of the bruising by hospice for 1 of 3 residents reviewed who met the criteria for skin conditions and 1 of 1 resident reviewed for hospice. The facility also failed to assess a resident for self administration of medication for 1 of 1 residents reviewed for self administration of medications. (Resident #90 and Resident #81)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #81 was reviewed on 11/18/12 at 11:00 a.m.</p> <p>The diagnoses for Resident #81 included, but were not limited to: neuropathy, history of cerebral vascular accident, and congestive heart failure.</p> <p>During an interview with Resident #81 on 11/15/12 at 11:31 a.m., 2 bruises</p>	F0309	<p>F 309 It is the practice of Manor Care Indy South to provide all residents with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? Resident #81 bruising was evaluated; RN#6 to receive 1:1 education on coordination of care with Hospice staff Resident #91 was assessed by IDT and found not able to participate in the self administration program at this time. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Hospice residents and those residents who choose to self administer their drugs are at risk and have the potential to be affected by this deficient practice. A chart review of residents who are receiving Hospice benefits was completed and coordination of care was identified. Residents</p>	12/20/2012	

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	<p>were observed on her lower right arm. Resident #81 proceeded to pull up her sleeve where more bruising was observed on her elbow area. Resident #81 indicated she received the bruises when being transferred by 2 staff members a week earlier, but could not remember the staff members names. She indicated she did tell someone, but couldn't remember who. She also indicated she wished the staff would be a little gentler, slower, and take their time more.</p> <p>On 11/15/12 at 2:00 p.m., the Administrator indicated the last incident involving Resident #81 was in August, 2012. He then proceeded to explain the above conversation involving Resident #81's bruising on her arm was overheard by a staff member and, as a result, an investigation had begun.</p> <p>During an interview with Family Member #5 on 11/16/12 at 1:00 p.m., she indicated, "They called me yesterday about the bruises and I thought, "Oh no, not again." I've noticed the CNA's (Certified nursing Assistants) tend to be in a hurry and not take their time."</p> <p>The hospice care plan, revised</p>		<p>desiring to self administer their drugs will be assessed by IDT. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Licensed nursing staffs have been in-serviced on the following: Ø Policy on Self Administration of Meds Ø Communication with hospice in coordinate of care How the corrective action will be monitored to ensure the deficient practice does not reoccur? ADNS or designee will monitor weekly the coordination of care with Hospice visits. Nursing staff will continue to exchange information before and after visits from Hospice nurse and or nursing assistant. This communication will be documented on the Hospice notes and in our progress note after each Hospice visit. ADNS or designee will monitor that residents at the time of admission to facility are informed about their rights, including their right to self administer their drugs as assessed by the IDT. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. Date to be completed 12/20/2012</p>				

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	<p>7/10/12, indicated the goal was, "Patient will not experience distress in coping with end stage of life." An intervention was, "Hospice nurse visits weekly-care coordinated between hospice and center".</p> <p>The 11/14/12 hospice notes indicated under the Alteration in Skin Integrity section, "Comment: bruising noted on rt (right) arm by elbow & wrist, pt (patient) denies any falls, pt states "people do that when they are helping me."" The Summary portion of this hospice note indicated, "Pt has bruising noted rt arm, denies any falls. POC (plan of care) communicated, coordinated & collaborated (symbol for "with") (name of RN #6) nurse." This 3 page hospice note was signed by Hospice Nurse #7 and RN #6 on 11/14/12.</p> <p>During an interview with the DON (Director of Nursing) on 11/16/12 at 1:28 p.m., she indicated the hospice nurse communicated with the nurse on the floor every time she came. She indicated she expected the hospice nurse to communicate any conditions she found and that the hospice nurse exited with the floor nurse every time they came.</p> <p>During a telephone interview with RN</p>			

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	<p>#6 on 11/20/12 at 10:55 a.m., she indicated Resident #81's hospice nurse gave her a paper to sign when the nurse exited. She stated, "I review it briefly. They tell me if she has any new areas." In regards to the bruising on Resident #81's arm noted in the 11/14/12 hospice note and signed by RN #6, RN#6 indicated, " I don't remember them telling me about it on the 14th or me reviewing it on the paperwork." She indicated the first she'd heard about Resident #81's bruising was on 11/15/12 when a conversation of Resident #81's was overheard by staff. She indicated, "I would have done an investigation right away, if I had known about it."</p> <p>The Investigation Report was provided by the Administrator on 11/20/12 at 1:20 p.m. The investigation included a telephone statement dated 11/16/12 from CNA #8 that indicated, "I took care of her (Resident #81) yesterday 2:30 -10:30 p""No bruises were noticed""I put the patient to bed & didn't see anything"" The report also included a Skin Alteration Record that indicated 4 "purple discolorations" on Resident #81's right arm.</p> <p>2. The clinical record for Resident #90 was reviewed, on 11/16/12 at 11:00 a.m. The diagnoses for</p>			

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	<p>Resident #90 included, but was not limited to: osteoarthritis.</p> <p>During an interview with Resident #90, on 11/13/2012 at 2:28 p.m., the resident indicated she did not have any pain because she would self administer BioFreeze Roll-on to herself during the day and when needed. Resident #90 then pulled out the BioFreeze medication, from her nightstand, for observation. The BioFreeze medication had a medication administration label on it from the Facility pharmacy.</p> <p>A review of the November Physician's Orders indicated BioFreeze Roll-on was to be applied topically to both knees, both feet, shoulders, and back twice daily.</p> <p>An assessment for self-administration of medication was not located in the clinical record and was requested on 11/16/12 at 11:45 p.m., from Consultant #3/DoN (Director of Nursing).</p> <p>During an interview with Consultant #3, on 11/16/12 at 2:00 p.m., she indicated she nor the DoN (Director of Nursing) were able to locate a self administration of medication assessment for Resident #90.</p>			

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	<p>Consultant #3 also indicated she was unsure of why the self administration assessment was requested and "was it because the Resident was self administering medication?"</p> <p>On 11/19/12 at 10:00 a.m., Resident #90 indicated she administered the BioFreeze all last week (11/11/12-11/15/12) to herself and no staff member provided administration of the medication to her. The Resident also indicated she had the medication for self-administration for about the past two weeks. Resident #90 indicated a staff member took away the BioFreeze from her on Friday (11/16/12) afternoon.</p> <p>During an interview with LPN #1, on 11/19/12 at 10:07 a.m., she indicated she administered the BioFreeze to Resident #90 last Friday (11/16/12), right after she "confiscated" the medication from the Resident that day. LPN#1 indicated she did not remember when she gave the medication before that date (11/16/12), but other nurses were supposed to be giving it during their shifts.</p> <p>On 11/20/12 at 10:55 a.m., Resident #90 indicated she received the medication from a nurse, but could</p>			

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	<p>not remember her name.</p> <p>The 9/4/12 Quarterly MDS (Minimum Data Set), indicated Resident #90 had a BIMS (Brief Interview of Mental Status) of 15, which was indicative no cognitive impairment.</p> <p>A review of the November MAR (Medication Administration Record) indicated BioFreeze was given twice daily on 11/11/12, 11/12/12, 11/13/12, 11/14/12 and once on 11/15/12, since there were initials in the dates listed on the MAR.</p> <p>At 11/20/12 at 11:27 a.m., Unit Manager #4 indicated no resident on B wing (the wing Resident #90 resided on) self administered medication to themselves. She also indicated when initials were listed in the date slot on the MAR, it indicated the medication was administered by a nurse on that date.</p> <p>On 11/29/12, at 11:30 a.m., the DoN (Director of Nursing), indicated there were no residents in the facility that self administer medication.</p> <p>During an interview with the Administrator on 11/20/12 at 1:20 p.m., he indicated he was aware of a resident self-administering medication</p>			

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	and the nurse, that left the medication in the resident's room, had been educated on the matter. 3.1-37(a)			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview the facility failed to comprehensively assess a resident's urinary continence status in order to prevent a decline in status for 1 of 3 residents reviewed for urinary incontinence. Resident #121.</p> <p>Findings included:</p> <p>Resident #121's clinical record was reviewed on 11/16/2012 at 1:30 pm. Diagnoses included but not limited to; chronic obstructive pulmonary disease, sepsis, hypertension, acid reflux, pneumonia, diabetes, and urinary tract infection.</p> <p>An admission MDS assessment completed on 6/29/2012 indicated, "Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent</p>	F0315	<p>F 315 It is the practice of Manor Care Indy South to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and restore normal bladder function. What corrective action will take place for those residents found to be affected by the deficient practice? Resident #121 was assessed for urinary continence status and was placed on an individual toileting program. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents who have a change in their continence status are at risk and have the potential to be affected</p>	12/20/2012

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	<p>voiding.)"</p> <p>A quarterly review MDS assessment completed on 9/21/2012 indicated, "Always incontinent (no episodes of continent voiding.)"</p> <p>A care plan indicated, "Revision date: 9/12/12. Focus: urinary incontinence r/t (related to) pressure ulcers, BPH (enlarged prostate), and immobility. Goal: minimize complications d/t (due to) incontinence. Interventions: apply skin moisturizers/barrier creams as needed. Place urinal/bedpan within resident's reach. Provide assistance with toileting. Provide incontinent care as needed. Report changes in skin integrity found during daily care. Report s & s (signs and symptoms) of UTI (urinary tract infection) such as flank pain, c/o (complaints of) burning/pain, fever, hematuria (blood in urine), change in mental status, etc. Therapy evaluation and treatment as ordered. Administer medication per physician's orders."</p> <p>An interview with the Director of Nursing (D.O.N.) on 11/20/2012 at 11:30 am indicated there is no toileting program. All the residents are just on a check and change schedule every two hours. There is no specific program that they can code on the</p>		<p>by this deficient practice. MDS of current residents have been reviewed within the past 6 months; those residents with noted decline in continence will be assessed and placed on an individual toileting program. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Licensed nursing staff will be in-serviced Ø Urinary Incontinence Practice Guide – Licensed Nurses Ø Reporting changes in a resident's continence status How will the corrective actions be monitored to ensure they do not occur again? ADNS or designee will monitor weekly during the morning meeting changes in a resident's continence status, this monitoring will also include weekly random staff interviews. ADNS or designee will monitor all new admission's continence status. Residents who are admitted with incontinence will be assessed per policy. If resident is a candidate for a toileting program one will be initiated. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. By what date will the changes occur? 12/20/2012</p>				

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	<p>MDS.</p> <p>An interview with the D.O.N. and Nurse Consultant on 11/20/2012 at 12:40 pm indicated they cannot prove they fully assessed the resident for incontinence. There is a form found in Resident #121's clinical record but there is no date listed, so it appeared that he was assessed but the staff never followed through with putting in place a bladder training program, and they didn't update the care plan. They are in transition currently. The old way they did things was focused more on determining what times the resident was experiencing incontinence. The new way is more comprehensive, it follows the flowchart. This is how they are going to put into place the new system currently and in the future.</p> <p>A 'Urinary Incontinence Practice Guide Flowchart' was provided by the D.O.N. on 11/20/2012 at 12:35 pm indicated, "Assessment -> Complete Patient Admission/Readmission Screen -> Does patient have history/evidence of incontinence? No -> Monitor for change in status. Yes -> Initiate bladder diary -> Complete Urinary incontinence evaluation -> Develop/Review Interim or Interdisciplinary care plan, toileting program as appropriate -></p>						

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	<p>Initiate/Update patient information worksheet, Kardex, task list -> Implement -> Ongoing management strategies: Patient/Family education: Staff education -> Evaluate."</p> <p>3.1-41(a)(2)</p>			

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F0412 SS=D	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review the facility failed to recognize and address a dental condition for 1 of 3 residents reviewed who met the criteria for dental status and services. (Resident #24)</p> <p>The clinical record for Resident #24 was reviewed on 11/19/12 at 1:00 p.m. and indicated Resident #24 was admitted to the facility on 7/27/07.</p> <p>The diagnoses for Resident #24 included, but were not limited to: diabetes and dementia.</p> <p>An observation of Resident #24's teeth were made on 11/15/12 at 1:26 p.m. Several teeth were missing. One appeared broken, and several were discolored and rotten.</p> <p>The 10/22/12 significant change MDS</p>	F0412	<p>F 412 It is the practice of Manor Care Indy South to provide or obtain from an outside resource, routine and emergency dental services to meet the needs of each resident. What corrective action will be accomplished for those residents who have been affected by the deficient practice? Resident #24 did receive an oral assessment as well as consented to see a dentist. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents who reside in facility are at risk and have the potential to be affected by this deficient practice. Each resident at the time of admission will receive information about dental services. It is our responsibility to provide or obtain dental services from an outside resource and emergency dental services to meet the needs of each resident.</p>	12/20/2012	

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	<p>(minimum data set) assessment indicated Resident #24 did not have any obvious or likely cavity or broken teeth.</p> <p>No dental care plan could be found in the clinical record.</p> <p>During an interview with the ADON (Assistant Director of Nursing) on 11/19/12 at 12:18 p.m., she indicated there was no specific dental care plan for Resident #24. She also indicated the dentist came to the facility every 3 months and that Resident #24's family did not consent to dental visits for Resident #24.</p> <p>During an interview with the DON (Director of Nursing) on 11/19/12 at 2:10 p.m., she indicated Resident #24 had not been seen by dentist since she was admitted and had no dental assessments since she'd been at the facility.</p> <p>During an interview with the Social Services Director on 11/19/12 at 2:10 p.m., he indicated, upon admission, Resident #24 was not approved for dental services, but did not know where the form indicating this was located. He confirmed that, "We don't know if she denied or approved it."</p>		<p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Social Service Director and Licensed nursing staffs have been in-serviced on: Ø Dental Evaluation/Assessment/Care Plans Ø F Tag 412 – Routine Dental Services How will corrective actions be monitored to ensure that they do not reoccur? Social Service Director will track and monitor that resident's who currently reside in facility receive routine dental exams. ADNS or designee will monitor that newly admitted residents and those with acute dental concerns receive timely assessment, care and ordered services. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. By what date will the changes occur? 12/20/2012</p>				

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	<p>During an interview with the ADON on 11/19/12 at 2:10 p.m., she indicated if the CNA's (Certified Nursing Assistants) noticed a dental condition on a resident, family would be notified. If family wanted to do something, they would follow through. She stated, "I look at my residents and would notice a dental condition." She indicated she hadn't noticed anything about Resident #24's dental condition and no one had brought anything to her attention. She stated, "Nursing does not regularly assess." She indicated MDS (minimum data set) completed the dental assessments for the dental portion of the MDS assessments.</p> <p>During an interview with MDS Coordinator #2 on 11/20/12 at 11:52 a.m. regarding how the dental section of the MDS assessment is completed, she indicated the resident's mouth is actually observed. She also indicated she, herself, did Resident #24's 10/22/12 significant change MDS assessment.</p> <p>An observation with MDS Coordinator #2 of Resident #24's oral cavity was made on 11/20/12 at 12:05 p.m. Several teeth were observed missing on top and all teeth observed were discolored and rotten. Resident #24</p>			

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	<p>stated, "I don't know how many I have in there." After the observation, MDS Coordinator #2 indicated, "I can see that I coded that wrong. It should say missing, broken, obvious cavity."</p> <p>During an interview with Social Services Coordinator #2 on 11/20/12 at 2:27 p.m., he indicated he spoke with Resident #24's POA (Power of Attorney) on 11/20/12 and was told, at this point, he was okay with Resident #24 seeing a dentist. He stated, "The dentist is coming in on the 28th and we can have her seen by him then."</p> <p>3.1-24(a)(1)</p>			