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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155495 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/16/2015 |
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| NAME OF PROVIDER OR SUPPLIER LAKELAND REHABILITATION AND HEALTHCARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 505 W 4TH ST MILFORD, IN 46542 |
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| F 000 Bldg. 00 | <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on January 27, 2015.</p> <p>Survey dates: March 12, 13 & 16, 2015</p> <p>Facility number: 000491 Provider number: 155495 AIM number: 100291230</p> <p>Survey team: Sharon Ewing, RN-TC Deb Kammeyer, RN Lora Swanson, RN Julie Wagoner, RN</p> <p>Census bed type: SNF: 5 SNF/NF: 41 Total: 46</p> <p>Census payor type: Medicare: 5 Medicaid: 33 Other: 8 Total: 46</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p> | F 000 | <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Post Survey Revisit completed on March 16, 2015. Please accept this Plan of Correction as the provider's credible allegation of compliance. Directed in-service training sent to Miles Collins, Enforcement Coordinator, ISDH.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p> | |

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

TITLE

(X6) DATE

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

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| F 272 SS=D Bldg. 00 | <p>16.2-3.1.</p> <p>Quality Review completed on March 20, 2015, by Brenda Meredith, RN.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by</p> | | | | |

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| | <p>the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interviews, the facility failed to ensure decline in bladder continence was thoroughly assessed for 1 of 3 residents reviewed for incontinence. (Resident #11) In addition, the facility failed to ensure bladder incontinency was thoroughly assessed for a newly readmitted resident in 1 of 3 residents reviewed for incontinence. (Resident #14)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #11 was reviewed on 03/13/15 at 9:12 A.M. Resident #11 was admitted to the facility on 09/07/14 with diagnoses, including but not limited to, hypertension, weakness, depression/anxiety, hemorrhoids, overactive bladder and hyperlipidemia.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 09/15/14, indicated the resident required extensive staff assistance for transfers and toileting needs and was continent of her bowels and bladder.</p> <p>The quarterly MDS assessment, completed on 12/12/14, indicated the</p> | F 272 | <p>F-272</p> <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: 1) Residents #11 and #14 bladder continence reviewed including care tracker elimination documentation, and MDS coding. Resident #14 will have a MDS completed, with ARD of 3/27/15, section H will be reviewed for accuracy before submission. Resident #11 had a MDS completed with ARD of 3/17/15 and care plan was updated.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All current residents have the potential to be affected by this alleged deficient practice. All current MDS records section H has been reviewed for coding accurately.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>1) Nursing staff to be re-educated on proper</p> | 04/03/2015 |

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| | <p>resident still required extensive staff assistance with transfers and toileting needs and was now frequently incontinent of her bladder. She remained continent of her bowels.</p> <p>An elimination record was completed for Resident #11 on 09/07/14 through 09/10/14. The record indicated the resident did not have any incontinent episodes.</p> <p>There was no other bladder incontinence assessment information located in the clinical record for Resident #11. The medical records nurse, LPN #10, provided a Bowel and Bladder Detail Report for Resident #11 on 03/13/15 at 11:30 A.M. The report, for 02/25/15 through 03/12/15, documented the dates and times the resident was toileted or was not toileted. The information indicated on 02/25/15 and 02/26/15 the resident was not toileted. On 02/27/15 at 11:34 A.M., the report indicated the resident was continent and had toileted herself. There was no documentation of any toileting activity for Resident #11 after the 11:34 A.M. toileting until 02/27/15 at 9:23 P.M., when the resident was toileted, required extensive assistance and was continent of her bladder. The toileting detail report continued to indicate long periods of time with no</p> | | <p>documentation of elimination in care tracker system and its importance for baseline assessment by Clinical Support Nurse by April 1, 2015</p> <p>2) DHS and/or designee will review nursing documentation during the assessment look back period per RAI manual, this may included Caretracker information for continence, staff interview, observation of resident.</p> <p>3) MDS nurse will notify the IDT of any change in bladder continence as identified during reference window</p> <p>4) DHS and/or designee will review/compare the target assessments to the next assessment for continence changes</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>1) DHS and/or designee will review nursing documentation during the assessment look back period per RAI manual, 3 times per week for 4 weeks , then weekly times 5 months- this may included Caretracker information for continence, staff interview, observation of resident.</p> | | |

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| | <p>toileting for Resident #11 and/or inconsistent toileting documentation where the resident toileted herself or required extensive staff assistance.</p> <p>On 03/16/15 at 10:20 A.M., the ADON (Assistant Director of Nursing), RN #11, provided a portion of the February 2015 nursing monthly summary assessment which indicated the resident wore pull ups, went to the bathroom, and had urge incontinence.</p> <p>The care plan regarding incontinence, which had been updated on 02/16/15, indicated the following: "I am incontinent of bladder at times r/t [related to] decreased mobility and an injury to my right shoulder from childhood. I am at risk for loss of dignity. I need assist for toileting. Check me for incontinence every two hours and prn [as needed]. Provide me with pericare after each incontinent episode. Ensure I have privacy during incontinence care. Offer me toileting during incontinence checks. Provide me with incontinence products for dignity and control. My goal is to maintain my dignity. Please review my interventions by 03/2015 to determine if any changes are needed." The care plan, although updated on 02/16/15 was not changed from the resident's previous care plan regarding incontinence.</p> | | <p>2) DHS and/or designee will review/compare the target assessments to the next assessment for continence changes 3 times per week for 4 weeks, then weekly times 5 months</p> <p>3) DHS and/or designee will review care tracker elimination record 3 times per week for 4 weeks for residents with MDS assessments due, then weekly times 5 months to ensure documentationDHS and or designee will forward the results of the audits and/or observations to QAA and will monitor monthly for six months or until 100% compliance is achieved.</p> <p>Completion Date: April 3, 2015</p> | |

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| | <p>During an interview on 03/16/15 at 9:12 A.M., the Director of Nursing indicated the bowel and bladder detailed report did say if the person was toileted or not. He indicated he would look for more bladder incontinence information for Resident #11.</p> <p>During an interview on 03/16/15 at 11:50 A.M., the facility nursing consultant, RN #16, indicated there was no further bladder incontinence assessment information for Resident #11.</p> <p>2. The clinical record for Resident #14 was reviewed on 03/12/15 at 2:20 P.M. Resident #14 was readmitted to the facility on 01/30/15 with diagnoses, including but not limited to, chronic obstructive pulmonary disease, congenital heart disease, dementia, seizures, depression, anxiety, chronic pain, recent onset atrial fibrillation (01/26/15), and gastroesophageal reflux disease.</p> <p>The Admission Minimum Data Set (MDS) assessment, completed on 02/06/15 for Resident #14 indicated she was occasionally incontinent of her bladder and required extensive staff assistance of 1 -2 staff for transfers and toileting needs.</p> | | | |

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| | <p>There was no bladder incontinence assessment information located on the clinical record for Resident #14. On 03/13/15 at 11:30 A.M., LPN #10 provided an 11 day Elimination Record/Schedule for the dates of 01/30/15 through 02/10/15 for Resident #14, however, there were gaps in the documentation on every day of the record. The most complete days had only 4 entries documented instead of the required 24 entries. In addition, a copy of a computerized Bowel and Bladder Detailed Entry Report for Resident #14 was provided for the timeframe of 01/30/15 through 2/10/15. On some dates there was only 2 toileting episodes documented in a 24 hour time frame. There was no other assessment documentation provided for Resident #14.</p> <p>The care plan for incontinence for Resident #14, updated on 03/03/15, indicated the following: "I am incontinent of bladder r/t decreased mobility. I am at risk for loss of dignity. I need assist for toileting. Check me for incontinence through out the day. Provide me with pericare after each incontinent episode. Ensure I have privacy during incontinence care. Offer me toileting during incontinence checks.</p> | | | | | | |

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| | <p>provide me with incontinence products for dignity and control. My goal is to maintain my dignity...."</p> <p>During an interview on 03/16/15 at 11:50 A.M., the facility nursing consultant, RN #16, indicated there was no further bladder incontinence assessment information for Resident #11.</p> <p>3. The current facility policy and procedure, titled "Guidelines for Circumstance and Reassessment Forms," dated 01/06, and provided by the ADON, on 03/13/15 at 2:21 P.M., indicated, "1. The appropriate "Circumstance and Reassessment Form" should be initiated as applicable to the specific episode...." A currently used form titled "Documentation Guidelines" was also provided. The form indicated for "New/changes with incontinence status. Removal/Insertion of catheter" the facility should complete an Elimination Circumstance form and Initiate or update the care plan.</p> <p>This deficiency was cited on 01/27/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-31(a)</p> | | | |

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| F 282 SS=D Bldg. 00 | <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 observation, record review and interviews, the facility failed to ensure the care plans for 2 of 3 residents reviewed for care plans was followed regarding toileting . (Residents #11 and 22)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #11 was reviewed on 03/13/15 at 9:12 A.M. Resident #11 was admitted to the facility on 09/07/14 with diagnoses, including but not limited to, hypertension, weakness, depression/anxiety, hemorrhoids, overactive bladder and hyperlipidemia.</p> <p>The quarterly MDS assessment, completed on 12/12/14, indicated the resident still required extensive staff assistance with transfers and toileting needs and was now frequently incontinent of her bladder. She remained continent of her bowels.</p> <p>The care plan regarding incontinence,</p> | F 282 | <p>F282 What corrective actions will be accomplished for residents found to have been affected by the deficient practice: Resident # 11 and #22 care plans reviewed and updated.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All resident residing at the campus have the potential to be affected by the alleged practice</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: 1) All care plans regarding incontinence will be reviewed to ensure it accurately portrays the resident's continence statatus and individualized approaches with each MDS completion. 2) Care plans will be reviewed and updated quarterly and as changes are identified. 3) Nursing staff to be re-in-serviced on viewing and following care plans by the Clinical Support Nurse by April 1, 2015. 4) Per the campus guidelines, the Nursing</p> | 04/10/2015 |

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| | <p>which had been updated on 02/16/15, indicated the following: "I am incontinent of bladder at times r/t [related to] decreased mobility and an injury to my right shoulder from childhood. I am at risk for loss of dignity. I need assist for toileting. Check me for incontinence every two hours and prn [as needed]. Provide me with pericare after each incontinent episode. Ensure I have privacy during incontinence care. Offer me toileting during incontinence checks. Provide me with incontinence products for dignity and control. My goal is to maintain my dignity. Please review my interventions by 03/2015 to determine if any changes are needed." The care plan, although updated on 02/16/15, was not changed from the resident's previous care plan regarding incontinence. There was no indication of the plan to indicate the resident was capable of toileting herself</p> <p>Resident #11 was observed on 03/13/2015 8:45 A.M. sitting in her recliner. The resident was assisted to transfer to her wheelchair and pushed to the activity lounge on 03/13/15 at 9:15 A.M. by the Activity Director, Employee #13. During an interview on 03/13/15 at 9:20 A.M., Employee #13 indicated she did not toilet Resident #11 before she pushed her to the activity lounge. Resident #11 remained in the activity</p> | | <p>Leadership Team will review the 24 hour report, and circumstance forms, in the daily clinical meeting and make the appropriate changes to the toileting/continence care plans 5 days a week, ongoing. 5)DHS and/or designee will observe 3 residents, 3 times per week during care to ensure compliance with toileting/continence care plan intervention for 4 weeks then weekly times 5 months and will report findings to QA&A for 6 months or until 100% compliance is achieved How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>1) All care plans regarding incontinence will be reviewed to ensure it accurately portrays the resident's continence status and individualized approaches with each MDS completion. 2) Care plans will be reviewed and updated quarterly and as changes are identified. 3) Per the campus guidelines, the Nursing Leadership Team will review the 24 hour report, and circumstance forms, in the daily clinical meeting and make the appropriate changes to the care plans 5 days a week, ongoing 4) DHS and/or designee will observe 3 residents, 3 times per week during care to ensure compliance with toileting/continence care plan intervention for 4 weeks then</p> | | |

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| | <p>lounge from 9:15 A.M. - 10:07 A.M. At 10:07 A.M., Resident #11 was observed propelling herself in her wheelchair from the activity lounge back to her room. On 03/13/15 at 10:12 A.M., Resident #11 was noted to have just arrived in her room. She propelled her wheelchair into her room and was facing her recliner. At 10:18 A.M., she was noted in the activity room. Interview with the Activity Director, Employee #13 indicated she had went to Resident #13's room and assisted her to the activity room. Employee #13 indicated she did not toilet Resident #11 and she was not toileted before she left her room to go to the Activity room. Resident #11 remained in the Activity room from 10:18 A.M. to 11:25 A.M. At 11:25 A.M., Resident #11 propelled herself from the Activity Room out into the hallway and was noted to complain about some missing items in her room. LPN #14 overheard Resident #11 and pushed her into her room and remained with Resident #11 in her room talking with her. At 11:30 A.M., LPN #14 pushed Resident #11 into the dining room and indicated she was going to get Resident #11 some hot tea because it "calmed" her. Resident #11 remained in the dining room and was noted to be assisted to order her noon meal by a dietary staff member at 11:45 A.M.</p> | | <p>weekly times 5 months and will report findings to QA&A for 6 months or until 100% compliance is achieved 5) DHS and/or designee will review toileting/continence care plans for accuracy 3 times per week for 4 weeks then weekly times 5 months to ensure documentation and will report findings to QA&A for 6 months or until 100% compliance is achieved. Completion Date: April 10, 2015</p> | |

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| | <p>During an interview on 03/13/2015 at 1:39 P.M. , CNA #15 indicated she had assisted Resident #11 to get up before breakfast and toileted her and then the resident took herself to the bathroom around 11:00 A.M. to 11:30 A.M. and she found her in the bathroom and helped her finish up. She indicated the resident would toilet herself and was usually continent. She indicated she would check her for incontinence when she got her up in the morning and again just before lunch. When queried if she was sure she had assisted the resident today before lunch with toileting CNA #15 insisted yes because the resident's wheelchair was located just outside the bathroom in her room when she helped her.</p> <p>2. On 3/13/15 at 9:48 A.M., the clinical record for Resident #22 was reviewed. Resident #22 was admitted, on 7/23/14, with diagnoses included, but not limited to, "...osteoarthritis, edema, delusional disorder, hypothyroidism, diabetes mellitus type II, anemia, depressive disorder and hypertension...."</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 2/10/15, indicated Resident #22's cognitive skills was moderately impaired, she required extensive assistance for toilet use, and</p> | | | |

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| | <p>was frequently incontinent.</p> <p>The current health care plan related to incontinence for Resident #22, revised on 3/4/15, indicated the resident was incontinent of bladder. The interventions included: "...Toilet before, after meals, when waking, and before bed and PRN [as needed]...."</p> <p>On 3/13/15, Resident #22 was noted at the following times:</p> <p>*9:41 A.M.-awake sitting up in her wheelchair watching her television.</p> <p>*10-15 A.M.-11:30 A.M.- continues to sit in her wheelchair in her room. No staff was observed to enter the resident's room during this time.</p> <p>*11:32 A.M.- a nurse entered Resident #22's room to give her an oral medication, she did not offer to take the resident to the restroom.</p> <p>*11:35 A.M.-CNA #1 entered the Resident #22's room and asked her is she was ready to go to the dining room for lunch. The resident indicated she was ready for lunch, CNA #1 assisted the resident in the wheelchair to the dining room. CNA #1 did not offer to assist the resident to the restroom prior to lunch.</p> <p>During an interview, on 3/13/15 at 1:55 P.M., CNA #1 indicated the resident requires the assist of 1 person to transfer</p> | | | |

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| F 315 SS=D Bldg. 00 | <p>on and off of the toilet. She further indicated the resident always goes to the restroom before and after lunch.</p> <p>This deficiency was cited on 01/27/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. Based on observation, record review and interviews, the facility failed to ensure</p> | F 315 | F-315 | 04/03/2015 |

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| | <p>decline in bladder continence was thoroughly assessed for 1 of 3 residents reviewed for incontinence. (Resident #11) In addition, the facility failed to ensure bladder incontinency was thoroughly assessed for a newly readmitted resident in 1 of 3 residents reviewed for incontinence. (Resident #14)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #11 was reviewed on 03/13/15 at 9:12 A.M. Resident #11 was admitted to the facility on 09/07/14 with diagnoses, including but not limited to, hypertension, weakness, depression/anxiety, hemorrhoids, overactive bladder, and hyperlipidemia.</p> <p>The initial Minimum Data Set (MDS) assessment, completed on 09/15/14, indicated the resident required extensive staff assistance for transfers and toileting needs and was continent of her bowels and bladder.</p> <p>The quarterly MDS assessment, completed on 12/12/14, indicated the resident still required extensive staff assistance with transfers and toileting needs and was now frequently incontinent of her bladder. She remained</p> | | <p>What corrective actions will be accomplished for residents found to have been affected by the deficient practice: 1) Residents #11 and #14 bladder continence reviewed including care tracker elimination documentation, and MDS coding. Resident #14 will have a MDS completed, with ARD of 3/27/15, section H will be reviewed for accuracy before submission. Resident #11 had a MDS completed with ARD of 3/17/15 and care plan was updated.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All current residents have the potential to be affected by this alleged deficient practice. All current MDS records section H has been reviewed for coding accurately.</p> <p>What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur:</p> <p>1) Nursing staff to be re-educated on proper documentation of elimination in care tracker system and its importance for baseline assessment by Clinical Support Nurse by April 1, 2015</p> <p>2) DHS and/or designee will</p> | | |

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| | <p>continent of her bowels.</p> <p>An elimination record was completed for Resident #11 on 09/07/14 through 09/10/14. The record indicated the resident did not have any incontinent episodes.</p> <p>There was no other bladder incontinence assessment information located in the clinical record for Resident #11. The medical records nurse, LPN #10, provided a Bowel and Bladder Detail Report for Resident #11 on 03/13/15 at 11:30 A.M. The report for 02/25/15 through 03/12/15 documented the dates and times the resident was toileted or was not toileted. The information indicated on 02/25/15 and 02/26/15 the resident was not toileted. On 02/27/15 at 11:34 A.M., the report indicated the resident was continent and had toileted herself. There was no documentation of any toileting activity for Resident #11 after the 11:34 A.M. toileting until 02/27/15 at 9:23 P.M. when the resident was toileted, required extensive assistance and was continent of her bladder. The toileting detail report continued to indicate long periods of time with no toileting for Resident #11 and/or inconsistent toileting documentation where the resident toileted herself or required extensive staff assistance.</p> | | <p>review nursing documentation during the assessment look back period per RAI manual, this may included Caretracker information for continence, staff interview, observation of resident.</p> <p>3) MDS nurse will notify the IDT of any change in bladder continence as identified during reference window</p> <p>4) DHS and/or designee will review/compare the target assessments to the next assessment for continence changes</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:</p> <p>1) DHS and/or designee will review nursing documentation during the assessment look back period per RAI manual, 3 times per week for 4 weeks , then weekly times 5 months- this may included Caretracker information for continence, staff interview, observation of resident.</p> <p>2) DHS and/or designee will review/compare the target assessments to the next assessment for continence changes 3 times per week for 4 weeks, then weekly times 5 months</p> | |

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| | <p>On 03/16/15 at 10:20 A.M., the ADON (Assistant Director of Nursing) provided a portion of the February 2015 nursing monthly summary assessment which indicated the resident wore pull ups, went to the bathroom, and had urge incontinence.</p> <p>Resident #11 was observed on 03/13/2015 8:45 A.M. sitting in her recliner. The resident was assisted to transfer to her wheelchair and pushed to the activity lounge on 03/13/15 at 9:15 A.M. by the Activity Director, Employee #13. During an interview with Employee #13, on 03/13/15 at 9:20 A.M. she indicated she did not toilet Resident #11 before she pushed her to the activity lounge. Resident #11 remained in the activity lounge from 9:15 A.M. - 10:07 A.M. At 10:07 A.M., Resident #11 was observed propelling herself in her wheelchair from the activity lounge back to her room. On 03/13/15 at 10:12 A.M., Resident #11 was noted to have just arrived in her room. She propelled her wheelchair into her room and was facing her recliner. At 10:18 A.M., she was noted in the activity room. Interview with the Activity Director, Employee #13 indicated she had went to Resident #13's room and assisted her to the activity room. Employee #13 indicated she did</p> | | <p>3) DHS and/or designee will review care tracker elimination record 3 times per week for 4 weeks for residents with MDS assessments due, then weekly times 5 months to ensure documentationDHS and or designee will forward the results of the audits and/or observations to QAA and will monitor monthly for six months or until 100% compliance is achieved.</p> <p>Completion Date: April 3, 2015.</p> | |

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| | <p>not toilet Resident #11 and she was not toileted before she left her room to go to the Activity room. Resident #11 remained in the Activity room from 10:18 A.M. to 11:25 A.M. At 11:25 A.M., Resident #11 propelled herself from the Activity Room out into the hallway and was noted to complain about some missing items in her room. LPN #14 overheard Resident #11 and pushed her into her room and remained with Resident #11 in her room talking with her. At 11:30 A.M., LPN #14 pushed Resident #11 into the dining room and indicated she was going to get Resident #11 some hot tea because it "calmed" her. Resident #11 remained in the dining room and was noted to be assisted to order her noon meal by a dietary staff member at 11:45 A.M.</p> <p>During an interview on 03/13/2015 at 1:39 P.M. , CNA #15 indicated she had assisted Resident #11 to get up before breakfast and toileted her and then the resident took herself to the bathroom around 11:00 A.M. to 11:30 A.M. and she found her in the bathroom and helped her finish up. She indicated the resident would toilet herself and was usually continent. She indicated she would check her for incontinence when she got her up in the morning and again just before lunch. When queried if she was</p> | | | |

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| | <p>sure she had assisted the resident today before lunch with toileting CNA #15 insisted yes because the resident's wheelchair was located just outside the bathroom in her room when she helped her.</p> <p>The care plan regarding incontinence, which had been updated on 02/16/15, indicated the following: "I am incontinent of bladder at times r/t [related to] decreased mobility and an injury to my right shoulder from childhood. I am at risk for loss of dignity. I need assist for toileting. Check me for incontinence every two hours and prn [as needed]. Provide me with pericare after each incontinent episode. Ensure I have privacy during incontinence care. Offer me toileting during incontinence checks. Provide me with incontinence products for dignity and control. My goal is to maintain my dignity. Please review my interventions by 03/2015 to determine if any changes are needed." The care plan, although updated on 02/16/15 was not changed from the resident's previous care plan regarding incontinence. There was no indication of the plan to indicate the resident was capable of toileting herself.</p> <p>During an interview on 03/16/15 at 9:12 A.M., the Director of Nursing indicated the bowel and bladder detailed report did</p> | | | |

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| | <p>say if the person was toileted or not. He indicated he would look for more bladder incontinence information for Resident #11.</p> <p>During an interview on 03/16/15 at 11:50 A.M., the facility nursing consultant, RN #16, indicated there was no further bladder incontinence assessment information for Resident #11.</p> <p>2. The clinical record for Resident #14 was reviewed on 03/12/15 at 2:20 P.M. Resident #14 was readmitted to the facility on 01/30/15 with diagnoses, including but not limited to, chronic obstructive pulmonary disease, congenital heart disease, dementia, seizures, depression, anxiety, chronic pain, recent onset atrial fibrillation (01/26/15), and gastroesophageal reflux disease.</p> <p>The Admission Minimum Data Set (MDS) assessment, completed on 02/06/15, for Resident #14 indicated she was occasionally incontinent of her bladder and required extensive staff assistance of 1 -2 staff for transfers and toileting needs.</p> <p>There was no bladder incontinence assessment information located on the clinical record for Resident #14. On</p> | | | | | | |

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| | <p>03/13/15 at 11:30 A.M., LPN #10 provided an 11 day Elimination Record/Schedule for the dates of 01/30/15 through 02/10/15 for Resident #14; however, there were gaps in the documentation on every day of the record. The most complete days had only 4 entries documented instead of the required 24 entries. In addition, a copy of a computerized Bowel and Bladder Detailed Entry Report for Resident #14 was provided for the timeframe of 01/30/15 through 2/10/15; however, on some dates there was only 2 toileting episodes documented in a 24 hour time frame. There was no other assessment documentation provided for Resident #14.</p> <p>The care plan for incontinence for Resident #14, updated on 03/03/15, indicated the following: "I am incontinent of bladder r/t decreased mobility. I am at risk for loss of dignity. I need assist for toileting. Check me for incontinence through out the day. Provide me with pericare after each incontinent episode. Ensure I have privacy during incontinence care. Offer me toileting during incontinence checks. provide me with incontinence products for dignity and control. My goal is to maintain my dignity...."</p> | | | |

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| | <p>During an interview on 03/16/15 at 11:50 A.M., the facility nursing consultant, RN #16, indicated there was no further bladder incontinence assessment information for Resident #11.</p> <p>3. The current facility policy and procedure, titled "Guidelines for Circumstance and Reassessment Forms, dated 01/06, and provided by the ADON, RN #11, on 03/13/15 at 2:21 P.M., indicated, "1. The appropriate "Circumstance and Reassessment Form" should be initiated as applicable to the specific episode...." A form currently used titled "Documentation Guidelines" was provided. The form indicated for "New/changes with incontinence status. Removal/Insertion of catheter" the facility should complete an Elimination Circumstance form and Initiate or update the care plan.</p> <p>This deficiency was cited on 01/27/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-42(a)(2)</p> | | | | |