

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155215	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/21/2014
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NAME OF PROVIDER OR SUPPLIER PLAINFIELD HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3700 CLARKS CREEK RD PLAINFIELD, IN 46168
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F000000	<p>This Visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00142499.</p> <p>Complaint IN00142499 substantiated with findings. Federal/State deficiencies related to the allegation(s) are cited at F160.</p> <p>Survey date(s): February 17, 18, 19, 20, & 21, 2014.</p> <p>Facility number: 000121 Provider number: 155215 AIM number: 100290940</p> <p>Survey Team: Lora Brettnacher, RN, TC Karen Hartman, RN Dorothy Plummer, RN Holly Duckworth, RN</p> <p>Census bed type: SNF: 16 SNF/NF: 82 Total: 98</p> <p>Census payor type: Medicare: 13 Medicaid: 60 Other: 25 Total: 98</p>	F000000	Preparation and/or execution of the plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and state law.	
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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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F000160 SS=E	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 02/28/2014 by Brenda Marshall, RN.</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. Based on interview and record review, the facility failed to convey, within 30 days upon death, the balance of a personal funds account to the individual or probate jurisdiction that administered the resident's estate, for 4 of 21 residents reviewed for conveyance of personal funds upon death (Resident B, C, D, and E).</p> <p>Findings include: On 2/20/14, Resident B's personal funds account was reviewed.</p>	F000160	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: Residents B, C, D, and E accounts were closed and refunds were processed.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. Facility BOM</p>	03/12/2014			

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	<p>Resident B expired on 12/10/2013. The Administrator indicated Resident B's account had not been closed as of 2/20/14, and the facility owed Resident B's responsible party \$1,535.</p> <p>On 2/20/14, Resident C's personal funds account was reviewed. Resident C expired on 11/21/13. The Administrator indicated Resident C's account had not been closed as of 2/20/14, and the facility owed Resident B's responsible party \$3,416.36.</p> <p>On 2/20/14, Resident D's personal funds account was reviewed. Resident D expired on 12/15/13. The Administrator indicated Resident D's account had not been closed as of 2/20/14, and the facility owed Resident D's estate \$2,818.50.</p> <p>On 2/20/2014, Resident E's personal funds account was reviewed. Resident E expired on 12/01/2013. The Administrator indicated Resident E's account had not been closed as of 2/20/14, and the facility owed Resident E's estate\$6,365.00.</p> <p>During an interview on 2/21/2014 at 3:20 P.M., the Administrator</p>		<p>reviewed all accounts where death had occurred to ensure that those accounts were closed and payments were processed, if necessary.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The facility developed a policy which states that refunds are to be made within 30 days for any resident that discharges or expires.</p> <p>4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: Administrator/designee will monitor discharges biweekly to ensure facility remains compliant. Findings will be reported to the Quality Assurance team on a quarterly basis.</p>				

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F000241 SS=D	<p>indicated the facility did not have a policy which indicated funds were to be conveyed within 30 days of a resident's death. He indicated the process would immediately be started to ensure funds owed by the facility would be paid.</p> <p>This Federal tag relates to Complaint IN00142499.</p> <p>3.1-6(h)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. Based on observation, interview and record review, the facility failed to promote dignity in regards to an uncovered urinary catheter bag for 1 of 3 residents reviewed for dignity of 6 residents who met the criteria for dignity in a Stage II sample of 31 (Resident #1).</p> <p>Findings include:</p>	F000241	<p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this facility to provide resident care in a manner and environment that maintains or enhances each resident's dignity and respect in</p>	03/12/2014

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	<p>During a Stage I resident observation on 02/18/2014 at 02:28 p.m., Resident #1 was observed lying in bed with a catheter bag hanging from the bottom right side of his bed. The resident had a visitor present in the room at the time.</p> <p>The record of Resident #1 was reviewed on 02/19/2014 at 11:41 a.m. Diagnoses included, but were not limited to, history of stroke with aphasia and dysphagia, chronic tube feed, history of seizures, urinary retention, diabetes, depression, left knee pain, contractures, agitation, chronic pain, tardive dyskinesia, and progressive dementia.</p> <p>A current recapitulation dated for February 2014, indicated, "...dx [diagnosis] urinary retension [sic]...anchor 16 Fr [French]..Foley cath [catheter]..."</p> <p>During an interview on 2/20/14 at 10:26 a.m., the Director of Nursing (DoN) indicated that there should have been foley catheter bag covers on all foley bags.</p> <p>During an observation on 2/20/2014 at 10:59 a.m., Resident #1, was observed lying in bed. The foley</p>		<p>full recognition of his/her individuality. Resident #1 had his catheter bag immediately covered.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with indwelling catheters have the potential to be affected by this deficient practice. Nursing staff will be in-serviced on maintaining resident dignity related to catheter bags.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Facility developed a dignity audit tool to monitor that all catheter bags are covered. The checking of catheter bags will be placed on CNA assignment sheets. DON or designee will complete dignity audit tool daily for 4 weeks, then 2 two times weekly for 4 weeks, then monthly thereafter.</p> <p>4. How the corrective actions(s) will be monitored to ensure the deficient practice will</p>				

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F000242 SS=E	<p>catheter bag was visible and uncovered at the side of the bed.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure residents were given a choice regarding their bathing schedules for 3 of 6 residents reviewed for choices of the 12 residents who met the criteria for choices in a Stage II Sample (Resident #30, #105, and #117).</p> <p>Findings include:</p> <p>1. Resident #30's record was reviewed on 2/19/14 at 10:36 A.M. Resident #30 had diagnoses which included, but were not limited to, senile delusion, chronic kidney disease, depression, and anxiety.</p>	F000242	<p>not recur: DON/designee will review the audit tool monthly and report findings to the Quality Assurance team on a quarterly basis.</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this facility to ensure that all residents have the right to make choices regarding their daily preferences. Resident #30, #105, and #117 were immediately asked their preference for shower/bathing and their preference was care-planned. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will</p>	03/12/2014	

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	<p>A care plan dated 12/13/13, indicated Resident #30 had moderately impaired cognition with a BIMS [Brief Interview Mini Status score] of 9 out of 15 (8-12 moderately impaired), had diagnoses of anxiety and depression, and would be allowed the highest level of independence when making choices regarding care. The record lacked documentation Resident #30's preferences regarding bathing/shower schedule had been assessed.</p> <p>2. Resident #105's record was reviewed on 2/20/2014 at 9:03 A.M. Resident #105 had diagnoses which included, but were not limited to, depression, mild mental retardation, seizures, muscle spasm, and urinary incontinence. A quarterly minimum data assessment tool [MDS] dated 10/4/2013, indicated Resident #105 moderately impaired cognition with a BIMS [brief mini mental status score] of 12 out of 15. The record lacked documentation Resident #105's preferences regarding shower/bathing schedule had been assessed.</p> <p>3. Resident #117's record was reviewed on 2/19/2014 at 11:13 A.M. Resident #117 had diagnosis</p>		<p>be taken: All residents have the potential to be affected by this deficient practice. All residents have the right to choose their preference with shower/bathing. All residents have been asked for their preference and if the resident is not able to give a preference due to cognitive status, their family members will be asked for their loved ones preference and the preference will be care-planned.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All residents or family members will be asked their preference on shower/bathing and preference will be care-planned. Facility created a new form which will be completed on admission that asks for resident shower/ bathing preference.</p> <p>4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: The DON/designee will review care plans during quarterly care</p>				

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	<p>which included, but was not limited to, quadriplegia. A 90 day scheduled MDS indicated Resident #117 was cognitively intact with a BIMs score of 15 out of 15 [13-15 no impairment]. The record lacked documentation Resident #117's preferences regarding shower/bathing schedule had been assessed.</p> <p>During an interview on 2/18/14 at 10:19 A.M., Resident #30 indicated she was not asked what her shower schedule preference was. She indicated she was "told" her time was "Thursday and Saturday."</p> <p>During an interview on 2/18/14 at 10:50 A.M., Resident #105 indicated he was "not allowed to choose" the days he took a bath/shower. He indicated if he refused on his scheduled day he would "not be allowed" to have a shower on an alternate day.</p> <p>During an interview on 2/18/2014 at 11:09 A.M., Resident #117 indicated he did not have a choice regarding his bathing/shower schedule. He indicated "they have a system" and he did not have a "choice."</p> <p>During an interview on 2/19/2014 at</p>		<p>plan meetings to ensure facility remains compliant. Results will be presented to the Quality Assurance committee on a quarterly basis.</p>				

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	<p>11:42 A.M., Licensed Practical Nurse [LPN] #12 indicated the residents' shower/bathing schedule was determined by their room number.</p> <p>During an interview on 2/19/2013 at 11:45 A.M., Unit Manager Registered Nurse [RN] #1 indicated she made the shower schedule out prior to discussing preferences with the residents. She indicated the facility did not have a system which proactively assessed residents' shower/bathing schedule preferences. She indicated if residents were not satisfied they would change their schedule.</p> <p>An undated policy titled "Bill of Resident Rights" identified as current by the Administrator on 2/21/14 at 11:50 A.M., indicated, "...You have the right to be treated with respect and dignity in recognition of your individuality and preferences... you have the right to participate in designing your plan of care/treatment...."</p> <p>3.1-3(u)(1)</p>				

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F000246 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.</p> <p>Based on observation, interview and record review the facility failed to provide accommodations in regards to providing a specialized chair for 1 of 8 residents reviewed for choices in a Stage II sample of 31 residents (Resident #1).</p> <p>Findings Include:</p> <p>On 2/17/14 at 1:51 p.m., Resident #1 was observed lying in bed. On 2/18/14 at 1:30 p.m., Resident #1 was observed lying in bed. On 2/18/14 at 2:28 p.m., Resident #1 was observed lying in bed. On 2/20/14 at 10:59 a.m., Resident #1 was observed lying in bed.</p> <p>During an interview on 2/20/14 at 10:26 a.m., the Director of Nursing (DoN) indicated that Resident #1 could no longer use his Braxton</p>	F000246	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this facility to provide services with reasonable accommodations of the individual needs and preferences. Resident #1 was placed in a new specialized chair purchased by facility. Resident #1 is put in chair daily per care plan.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. Any resident who needs and does not</p>	03/12/2014

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	<p>chair. She indicated that it had been approximately two weeks since he was able to get up in the chair. The DoN indicated that she was not sure of the reason that the chair became unusable and deferred to Registered Nurse (RN) #11. The DoN indicated that Resident #1 was bed bound until the facility was able to get the appropriate chair.</p> <p>During an interview on 2/20/14 at 2:08 p.m., RN #11 indicated that Resident #1 was unable to continue using the Braxton chair because there were rips in the fabric which created an infection control issue.</p> <p>The record of Resident #1 was reviewed on 02/19/2014 at 11:41 a.m.</p> <p>Diagnoses included, but were not limited to, history of stroke with aphasia and dysphagia, chronic tube feed, history of seizures, urinary retention, diabetes, depression, left knee pain, contractures, agitation, chronic pain, tardive dyskinesia, and progressive dementia.</p> <p>The most recent annual Minimum Data Set (MDS) assessment, dated 10/01/2013, indicated that Resident #1 was severely cognitively impaired utilizing the staff assessment for</p>		<p>have a proper specialized wheel chair, will be referred to therapy by the nursing department.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Residents identified as needing evaluation for specialized equipment will be referred to therapy for evaluation. Facility will obtain equipment per therapy recommendation. Nursing staff will be in-serviced on communicating with therapy department.</p> <p>4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: DON/designee will review therapy referrals for specialized wheel chairs monthly to ensure reasonable accommodation of needs have been maintained. Results will be presented to the Quality Assurance team on a quarterly basis.</p>		

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	<p>mental status. Resident #1 was indicated to be an extensive assist with a 2 plus person physical assist for bed mobility and transferring.</p> <p>The most recent recapitulation, dated for February 2014, indicated a physician's order for ..."Up in Braxton chair via Hoyer lift et [and] staff assist daily for 2 hours on 6-2 shift...Resident may participate in activities per plan...."</p> <p>A care plan, dated 10/02/13, "...Resident is up several times during the month and seated in either the dining room [or] the lobby for environmental stimulation..."</p> <p>A care plan, dated 10/2/2013, "...Total dependence on staff for all aspect os [sic] care due to impaired cognition...propel Braxton chair to/from destinations..."</p> <p>A care plan, dated 10/2/2013, "...Risk for falls due to dependent for transfers related to legs are contracted...up in Braxton chair daily...."</p> <p>During an interview on 2/20/2014 at 9:51 a.m., the Activities Director indicated that Resident #1 typically got out of his room to participate in</p>			

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	<p>one on one activities once or twice per week.</p> <p>During an interview on 2/21/14 at 10:50 a.m., CNA #9 indicated that Resident #1 was supposed to be up in his chair every day. CNA #9 indicated that the resident was no longer able to use his chair and that she had not seen him out of bed or participating in any activities over the past few weeks.</p> <p>3.1-3(v)(1)</p>			

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review the facility failed to develop care plans related to range of motion and risk for developing pressure ulcers for 2 residents in a Stage II sample of 31. (Resident #1, Resident #129)</p> <p>Findings include:</p> <p>1. The record of Resident #1 was reviewed on 02/19/2014 at 11:41 a.m. Diagnoses included, but were not limited to, contractures, history of stroke with aphasia and</p>	F000279	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet resident's medical, nursing, and mental and psychosocial needs. Resident #1 is on therapy case load for range of motion and</p>	03/12/2014	

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	<p>dysphagia, chronic tube feed, history of seizures, urinary retention, diabetes, depression, left knee pain, agitation, chronic pain, tardive dyskinesia, and progressive dementia.</p> <p>The most recent annual Minimum Data Set (MDS) assessment, dated 10/01/2013, indicated that Resident #1 was severely cognitively impaired utilizing the staff assessment for mental status. Resident #1 was indicated to be an extensive assist with a 2 plus person physical assist for bed mobility and transferring. Resident #1 had functional limitation in range of motion of the upper extremity on one side. The resident had functional limitation in range of motion of the lower extremities on both sides.</p> <p>Care plan dated 10/2/2013 "...Total dependence on staff for all aspect os [sic] care due to impaired cognition associated with progressive dementia, chronic pain, aphasia, functional limitation associated with history of CVA, lower extremity contractures, left hand contracture rarely out of bed. Is NPO [nothing by mouth] and has feeding tube...turn/reposition every two hours and PRN [as needed]...."</p>		<p>positioning and has a care plan addressing range of motion. Resident #129 Braden scale has been updated and a pressure ulcer risk care plan and an open area care plan have been developed.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. All residents who have contractures have a care plan addressing range of motion. All residents Braden scales have been updated and any resident who is at risk for pressure ulcers have a care plan for pressure ulcer risk.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All residents will be reviewed quarterly, annually and with significant change for contractures and care plan will be updated as appropriate. All residents will have a Braden</p>		

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	<p>Care plan lacked documentation for restorative nursing services or range of motion related to contractures.</p> <p>During a Stage I observation on 2/18/14 at 1:54 p.m., Resident #1 was observed to have a contraction of his left upper extremity.</p> <p>During a Stage I interview on 2/18/14 at 1:54 p.m., Registered Nurse (RN) #11 indicated that Resident #1 had contractures of bilateral knees, bilateral ankles, and bilateral elbows. RN #11 indicated that range of motion services and splint devices were not in place. RN #11 was unable to locate a plan of care for restorative nursing.</p> <p>During an interview on 2/20/14 at 10:26 a.m., the Director of Nursing (DoN) indicated that Resident #1 was not receiving any services related to range of motion. The DoN indicated that Resident #1 was not participating in a restorative program, but that staff had been turning and repositioning the resident.</p> <p>During an interview on 2/21/14 at 10:50 a.m., CNA #9 indicated that Resident #1 required total care.</p>		<p>Scale updated quarterly, annually, and with significant change. Unit Managers and MDS Coordinators will be in-serviced developing care plan. 4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: DON/designee will monitor care plans on a quarterly basis. Findings will be reported to the Quality Assurance team on a quarterly basis.</p>		

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	<p>CNA #9 indicated that Resident #1 needed to be repositioned at least every 2 hours and that his legs were contracted. CNA #9 indicated that positioning was important.</p> <p>During an interview on 2/21/14 at 2:35 p.m., the DoN indicated that there were no records in current or past medical records indicating that Resident #1 had received any sort of restorative nursing, OT (occupational therapy), or PT (physical therapy), and no records of the family declining services.</p> <p>At the time of the exit conference on 2/21/14 at 4:20 p.m., the facility lacked documentation of care related to range of motion.</p> <p>2. The record of Resident #129 was reviewed on 2-19-2014 at 1:45 p.m. Resident #129 was admitted to the facility on 2-6-2014 at 3:20 p.m. Diagnoses included but was not limited to open reduction with internal fixation to left hip, carotid stenosis, hypertension, chronic obstructive lung disease, diabetes mellitus, and chronic renal insufficiency.</p> <p>The record of Resident #129 lacked the documentation of a plan of care addressing the risk for the</p>			

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	<p>development a pressure area for a resident assessed as being at risk for the development of a pressure area.</p> <p>The Nursing Admission Assessment dated 2-06-2014, under the section titled Skin Problems, indicated Resident #129 had 2 incisions. In the section titled Additional Information, Resident #129 was assessed as having no open areas.</p> <p>A Braden Scale -- For Predicting Pressure Sore Risk was completed 2-07-2014, and the assessment indicated Resident #129 was at risk for developing a pressure sore. The assessment indicated Resident #129 was chairfast in the risk factor activity, had very limited mobility, and had a potential problem with friction and shearing.</p> <p>During an interview with RN#2 on 2-19-2014 at 2:00 p.m., RN #2 indicated Resident #129 did not have a careplan in place which addressed the potential for skin breakdown, nor did Resident #129 have a careplan in place addressing the open area on the buttocks.</p> <p>3.1-35(a)</p>						

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F000282 SS=E	<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, interview and record review the facility failed to follow the resident plan of care in regards to getting up in a chair daily and oral care for 2 residents in a Stage II sample of 31 (Resident #1, Resident #30).</p> <p>Findings include:</p> <p>1. The record of Resident #1 was reviewed on 02/19/2014 at 11:41 a.m.</p> <p>Diagnoses included, but were not limited to, history of stroke with aphasia and dysphagia, chronic tube feed, history of seizures, urinary retention, diabetes, depression, left knee pain, contractures, agitation, chronic pain, tardive dyskinesia, and progressive dementia.</p> <p>The most recent annual Minimum Data Set (MDS) assessment, dated 10/01/2013, indicated that Resident #1 was severely cognitively impaired utilizing the staff assessment for</p>	F000282	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this facility to provide or arrange services by qualified persons in accordance with each resident's written plan of care. Resident #1 is on therapy case load, has proper specialized wheel chair and is up in a specialized wheel chair per care plan. Resident #30 was immediately provided oral care.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. Any resident who needs and does not have a proper</p>	03/12/2014
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	<p>mental status. Resident #1 was indicated to be an extensive assist with a 2 plus person physical assist for bed mobility and transferring.</p> <p>The most recent recapitulation, dated for February 2014, indicated a physician's order for ..."Up in Braxton chair via Hoyer lift et [and] staff assist daily for 2 hours on 6-2 shift...Resident may participate in activities per plan...."</p> <p>A care plan, dated 10/02/13, "...Resident is up several times during the month and seated in either the dining room [or] the lobby for environmental stimulation..."</p> <p>A care plan, dated 10/2/2013, "...Total dependence on staff for all aspect os [sic] care due to impaired cognition...propel Braxton chair to/from destinations..."</p> <p>A care plan, dated 10/2/2013, "...Risk for falls due to dependent for transfers related to legs are contracted...up in Braxton chair daily...."</p> <p>On 2/17/14 at 1:51 p.m., Resident #1 was observed lying in bed. On 2/18/14 at 1:30 p.m., Resident</p>		<p>specialized wheel chair will be referred to the therapy department. ADL grids for CNA's have been updated to include a box to be checked that oral care has been given.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Residents identified as needing evaluation for specialized equipment will be referred to the therapy department. Facility created a dignity audit tool. DON/designee will complete the dignity audit tool daily for 4 weeks, then two times weekly, then monthly thereafter. The Nursing staff will be in-serviced on oral care and documentation and following plan of care.</p> <p>4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: DON/designee will monitor audit tool on a monthly basis and report findings to the Quality Assurance team quarterly.</p>				

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	<p>#1 was observed lying in bed. On 2/18/14 at 2:28 p.m., Resident #1 was observed lying in bed. On 2/20/14 at 10:59 a.m., Resident #1 was observed lying in bed.</p> <p>During an interview on 2/20/14 at 10:26 a.m., the Director of Nursing (DoN) indicated that Resident #1 could no longer use his Braxton chair. She indicated that it had been approximately two weeks since he was able to get up in the chair. The DoN indicated that she was not sure of the reason that the chair became unusable and deferred to Registered Nurse (RN) #11. The DoN indicated that Resident #1 was bed bound until the facility was able to get the appropriate chair.</p> <p>During an interview on 2/20/14 at 2:08 p.m., RN #11 indicated that Resident #1 was unable to continue using the Braxton chair because there were rips in the fabric which created an infection control issue.</p> <p>2. During observations on 2/18/2014 at 10:38 A.M. and 1:30 P.M., Resident #30 was observed to have yellow debris between her teeth.</p> <p>Resident #30's record was reviewed on 2/19/14 at 10:36 A.M. Resident</p>						

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	<p>#30 had diagnoses which included, but were not limited to, senile delusion, chronic kidney disease, depression, and anxiety.</p> <p>A care plan dated 12/13/13, indicated Resident #30 had moderately impaired cognition with a BIMS [brief interview mini status score] of 9 out of 15 (8-12 moderately impaired), had a self-care deficit and required staff assistance with all care with the exception of feeding. A goal indicated she would participate in daily care within the limits of her ability. Interventions included staff would assist her with oral care twice daily and as needed.</p> <p>During an interview on 2/18/14 at 10:32 A.M., Resident #30 indicated staff did not help her as necessary to clean her teeth. She indicated it had been "four or five days" since staff had cleaned her teeth. She indicated she did the best she could and she had rinsed her teeth with hot coffee that morning in an attempt to clean them. Resident #30 stated, "...I told the girl this morning I was going to report this. I can not stand dirty teeth."</p> <p>During an interview on 2/18/2014 at</p>						

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F000312 SS=D	<p>10:45 A.M., CNA [Certified Nursing Assistant] #13 indicated Resident #30's teeth were cleaned at night. She stated, "No, I did not clean them this morning because they are cleaned at night."</p> <p>During an interview on 2/20/14 at 3:00 P.M., the DON [Director of Nursing] indicated the facility did not currently document oral care provided to residents and could not provide documentation which indicated Resident #30 had been provided with oral care.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed</p>	F000312	1. What corrective action(s) will be accomplished for those residents	03/12/2014

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	<p>to ensure oral care was provided for 1 of 6 residents, who met the criteria for activities of daily living care in the Stage II Sample (Resident #30).</p> <p>Findings include:</p> <p>During observations on 2/18/2014 at 10:38 A.M. and 1:30 P.M., Resident #30 was observed to have yellow debris between her teeth.</p> <p>Resident #30's record was reviewed on 2/19/14 at 10:36 A.M. Resident #30 had diagnoses which included, but were not limited to, senile delusion, chronic kidney disease, depression, and anxiety.</p> <p>A care plan dated 12/13/13, indicated Resident #30 had moderately impaired cognition with a BIMS [brief interview mini status score] of 9 out of 15 (8-12 moderately impaired), had a self-care deficit and required staff assistance with all care with the exception of feeding. A goal indicated she would participate in daily care within the limits of her ability. Interventions included staff would assist her with oral care twice daily and as needed.</p> <p>During an interview on 2/18/14 at</p>		<p>found to have been affected by the deficient practice: It is the practice of this facility to provide the necessary services to maintain good nutrition, grooming, and personal oral hygiene. Resident #30 received oral care per plan of care and is documented daily by CNA's on the ADL grid.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. ADL grids for CNA's have been updated to include a box to be checked that oral care has been given.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: ADL grids for CNA's have been updated to include a box to be checked that oral care has been given. Nursing staff will be in-serviced on oral care and documentation. DON/designee will complete the</p>	

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	<p>10:32 A.M., Resident #30 indicated staff did not help her as necessary to clean her teeth. She indicated it had been "four or five days" since staff had cleaned her teeth. She indicted she did the best she could and she had rinsed her teeth with hot coffee that morning in an attempt to clean them. Resident #30 stated, "...I told the girl this morning I was going to report this. I can not stand dirty teeth."</p> <p>During an interview on 2/18/2014 at 10:45 A.M., CNA [Certified Nursing Assistant] #13 indicated Resident #30's teeth were cleaned at night. She stated, "No, I did not clean them this morning because they are cleaned at night."</p> <p>During an interview on 2/20/14 at 3:00 P.M., the DON [Director of Nursing] indicated the facility did not currently document oral care provided to residents and could not provide documentation which indicated Resident #30 had been provided with oral care.</p> <p>3.1-38(b)(1)</p>		<p>dignity audit tool daily for 4 weeks, then 2 times weekly, then monthly thereafter. 4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: DON/designee will monitor audit tool quarterly to ensure facility remains compliant. Findings will be reported to the Quality Assurance team on a quarterly basis.</p>		

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F000325 SS=G	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on interview and record review, the facility failed to ensure a resident maintained acceptable weight parameters. One of 4 residents, who were reviewed for weight loss in a Stage II sample of 31, had a 16 pound weight loss in 30 days. (Resident #93)</p> <p>Findings include: The record of Resident #93 was reviewed on 2-19-2014 at 10:00 a.m. Diagnoses included but were not limited to senile dementia with agitation and aggression, paranoia, arthritis, osteoporosis, osteoarthritis, hypothyroidism, and a history of cerebral vascular accident. A quarterly Minimum Data Set (MDS) assessment dated 10-2-2013 indicated Resident #93 was unable to complete the Brief Interview for</p>	F000325	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this facility to ensure that a resident maintains acceptable parameters of nutritional status and receives a therapeutic diet when there is a nutritional problem. Resident #93 is weighed weekly, monitored in SWAT(skin, weight, assessment team)weekly, and is currently receiving nutritional supplement. Resident #93 weight is stable. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the</p>	03/12/2014			

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	<p>Mental Status (BIMS). Resident #93 was indicated to be moderately impaired in cognitive skills for daily decision making, decisions were poor, and cues and supervision were required.</p> <p>A review of the Monthly Weight Record for Resident #93 included: 9-3-2013 weight 130 pounds, 10-4-2013 weight 126 pounds, 11-5-2013 weight 130.2 pounds, 12-4-2013 weight 114 pounds, 1-7-2014 weight 118 pounds, and 2-7-2014 weight 131 pounds.</p> <p>The most recent physician's recapitulation orders for Resident #93, signed and dated 1-26-2014, included orders for a regular diet with mighty shake and ice cream with all meals. Physician's orders also included... "Ensure 240 ml [milliliter] by mouth three daily with meals - Diagnosis: Supplement (chart % [percent] consumed) and Resource 2.0 120 ml by mouth three times daily between meals - Diagnosis: Supplement (chart % consumed)"....</p> <p>A dietary progress noted dated 12-16-2013 indicated "Wt [weight] 12/10/2013 = 114# [pounds] ... [decrease] 16# (12.26%) x [times]1</p>		<p>potential to be affected by this potential deficient practice. All weights will be reviewed to ensure any significant weight loss is referred to dietitian and physician for recommendations and any orders.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All residents who are receiving nutritional supplements will have supplements administered per physician order. Any resident that triggers a 5% weight loss in 30 days or 10% weight loss in 180 days will be added to weekly weights and will be referred to dietitian and reported to resident's physician. Dietitian's recommendations will be reported to physician and facility will follow physician orders. Facility created a monitoring tool to track administration of nutritional supplements. Nursing staff will be in-serviced on following physician orders. 4. How the corrective actions(s) will be</p>				

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	<p>month; [decrease] 12# (9.5%) x 6 months...."</p> <p>Resident #93 was seen by a nurse practitioner on 1-2-2014. The Assessment and Plan indicated... "4. Wt [weight] loss 4. Add Remeron - mighty shake...". A physician's order was written 1-2-2014 for Remeron 7.5 mg (milligram) by mouth at bedtime; diagnosis poor appetite.</p> <p>A pre-albumin level was checked on 2-12-2014. Results were indicated to be low, at 14 mg/dl (milligrams/deciliter), with a reference range of 20-40 mg/dl.</p> <p>Medication administration records (MAR) for Resident #93 were reviewed on 2-20-2014 at 9:45 a.m., for the months of November 2013, December 2013, and January 2014. The MAR for the months of November and December lacked documentation of the administration of Ensure; the MAR for December also lacked documentation of the administration of mighty shakes with meals. The weight of the resident decreased from 130.2 pounds in November 2013 to 114 pounds in December 2013. Documentation of the administration of Ensure was noted on the MAR of Resident #93</p>		<p>monitored to ensure the deficient practice will not recur: Dietary Manager/designee will monitor weights weekly and report findings to the Quality Assurance Committee on a quarterly basis. DON/designee will monitor tracking tool monthly and report findings to the Quality Assurance team on a quarterly basis.</p>				

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	<p>for the month of January 2014. The weight of Resident #93 was noted to increase to 131 pounds in February 2014.</p> <p>During an interview with LPN #5 on 2-20-2014 at 10:30 a.m., LPN #5 indicated "There was not documentation of the Ensure being administered for November or December. It was caught for January, and is on the sheets since then." In regards to the weight loss, LPN #5 indicated Resident #93, "Has refused meals, and needs encouragement to consume 25-50 percent when she eats."</p> <p>3.1-46</p>			

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to label over the counter medications with specific resident names in 1 of 7 medication</p>	F000431	1. What corrective action(s) will be accomplished for those residents found to have been affected by the	03/12/2014			

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	<p>carts reviewed for medication labeling and storage.</p> <p>Findings include:</p> <p>On 2-21-2014 at 11:00 a.m., the medication cart for the Maple Unit was observed to have 5 opened bottles of medications, which lacked specific resident name, and physician name. The opened bottles included 2 bottles of a medication named stool softener, 2 bottles of a medication named Geri-cot, and 1 bottle of a medication named aspirin.</p> <p>During an interview with RN #1 on 2-21-2014 at 11:00 a.m., RN #1 indicated the bottles were removed from the EDK (Emergency Drug Kit) for over the counter medications. RN #1 indicated the bottles should have been labeled with the name and room number of the resident, as well as the name of the physician. RN #1 indicated the bottles were opened and unlabelled, and had the potential to be administered to residents who were dispensed medications from the medication cart on the Maple Unit.</p> <p>3.1-25(j)(l)</p>		<p>deficient practice:</p> <p>It is the practice of this facility to have all drugs labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and expiration date when applicable. The 5 bottles of medications were immediately labeled.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. All medication carts were audited to ensure that all medications were properly labeled.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Facility developed an audit tool to be used weekly for 4 weeks, then 2 times for 1 month, then monthly thereafter. Nursing staff will be in-serviced on medication labeling.</p>		

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to provide accurate documentation in regards to a resident getting up in a chair for 1 Resident in a Stage II sample of 31 (Resident #1).</p> <p>Findings include:</p>	F000514	<p>4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: DON/designee will monitor the audit tool monthly to ensure medications are properly labeled and will report findings to the Quality Assurance team on a quarterly basis.</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: It is the practice of this facility to maintain clinical record on each resident in accordance with accepted professional</p>	03/12/2014			

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	<p>The record of Resident #1 was reviewed on 02/19/2014 at 11:41 a.m. Diagnoses included, but were not limited to, contractures, history of stroke with aphasia and dysphagia, chronic tube feed, history of seizures, urinary retention, diabetes, depression, left knee pain, agitation, chronic pain, tardive dyskinesia, and progressive dementia.</p> <p>The most recent annual Minimum Data Set (MDS) assessment, dated 10/01/2013, indicated that Resident #1 was severely cognitively impaired utilizing the staff assessment for mental status. Resident #1 was indicated to be an extensive assist with a 2 plus person physical assist for bed mobility and transferring.</p> <p>The most recent recapitulation, dated for February 2014, indicated a physician's order for ..."Up in Braxton chair via Hoyer lift et [and] staff assist daily for 2 hours on 6-2 shift...Resident may participate in activities per plan...."</p> <p>During an interview on 2/20/14 at 10:26 a.m., the Director of Nursing (DoN) indicated that Resident #1 could no longer use his Braxton chair. She indicated that it had been</p>		<p>standards and practices that are complete, accurately documented, readily assessable and systematically organized. Staff member in question was disciplined and educated on documentation.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by this deficient practice. Nursing staff will be in-serviced on documenting properly.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Facility developed a documentation audit tool to ensure facility remains compliant.</p> <p>4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur: DON/designee will monitor audit tool daily for 4 weeks then 2 times weekly for for 4 weeks, then monthly thereafter. Findings will be</p>		

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	<p>approximately two weeks since he was able to get up in the chair. The DoN indicated that she was not sure of the reason that the chair became unusable and deferred to Registered Nurse (RN) #11. The DoN indicated that Resident #1 was bed bound until the facility was able to get the appropriate chair.</p> <p>During an interview on 2/20/14 at 2:08 p.m., RN #11 indicated that Resident #1 was unable to continue using the Braxton chair because there were rips in the fabric which created an infection control issue.</p> <p>During a record review on 2/20/14 at 1:40 p.m., a treatment administration record (TAR), dated 02/01/14-02/28/14 was reviewed. The TAR indicated, "...up in Braxton chair via Hoyer lift et [and] staff assist daily for 2 hours on 6-2 shift...." Initials were noted in the 6-2 shift each day for February 1-20 in the documentation box.</p> <p>During an interview on 2/20/14 at 2:23 p.m., the TAR, dated 02/01/14-02/28/14, was reviewed with RN #11. The record indicated, "...up in Braxton chair via Hoyer lift et [and] staff assist daily for 2 hours on 6-2 shift...." Initials were noted in</p>		reported to the Quality Assurance team on a quarterly basis.	

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	<p>the 6-2 shift each day for February 1-20 in the documentation box. RN #11 indicated that the initials marked in the boxes meant that the activity had occurred. RN #11 indicated that the initials were marked incorrectly on the flow sheet as the resident had not been up in his chair.</p> <p>3.1-50(a)(2)</p>			