

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2016
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NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00204951.</p> <p>Complaint IN00204951 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F223, F226, F328, and F425.</p> <p>Survey dates: July 20 and 21, 2016</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type: Medicare: 2 Medicaid: 54 Other: 10 Total: 66</p> <p>Sample: 18</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Craig A. Hestand HFA, Executive Director 08/05/2017	

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 0157 SS=G Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the resident's</p>	F 0157	Jasper F-157	08/17/2016			

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	<p>physician and family member of a change in condition, for 1 of 3 residents reviewed regarding notification, in a sample of 18. Resident B</p> <p>Findings include:</p> <p>The closed clinical record of Resident B was reviewed on 7/20/16 at 2:15 P.M. Diagnoses included, but were not limited to, dementia, congestive heart failure, and acute kidney failure.</p> <p>A Minimum Data Set (MDS) assessment, dated 4/1/16, indicated the resident scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance of two + staff for toilet use. The MDS assessment indicated the resident "had an ostomy, or did not have a bowel movement for the entire 7 days."</p> <p>A Vital Signs report, dated 6/14/16, indicated the resident's blood pressure was 120/68, pulse was 70, and temperature was 97.3.</p> <p>A Physician's Note, dated 6/21/16, indicated, "Tolerating colostomy - Continue with current meds/tx [treatments]...."</p> <p>Progress Notes included the following</p>		<p>F157 Notification of changes</p> <p>What corrective action(s) will be Accomplished for those residents Found to have been affected by the Deficient practice:</p> <ul style="list-style-type: none"> Resident B has passed away <p>How will you identify other residents</p> <p>Having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> All residents have the potential to be affected by the alleged deficient practice. Resident progress notes will be reviewed daily by the DNS/designee to identify change of condition documented with further review to ensure MD/family notifications were completed and 	

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	<p>notations:</p> <p>6/26/16 at 1:53 A.M.: "Resident resting quietly at present. Resident had emesis [vomiting] earlier this shift x 1, will cont. to monitor. HOB [head of bed] elevated, no SOA [shortness of air] noted d/t Chronic Obstructive Pulmonary Disease."</p> <p>A Vital Signs report, dated 6/26/16 at 1:49 P.M., indicated the resident's blood pressure was 89/50, blood sugar was 243 "High," and pulse was 98.</p> <p>Progress Notes continued:</p> <p>6/26/16 at 1:54 P.M.: "Res. [resident] is not feeling good this day, he is cool and clammy, not eating, but is drinking well. He stated 'I feel O.K.' Blood sugar running higher than normal and was given s/s [sliding scale] insulin as order. B/P [blood pressure] is running low. Place a cool cloth on res. head. Res. is alert to name, touch, and can answer questions appropriated [sic]."</p> <p>An "Event Report," dated 6/26/16 at 2:00 P.M., indicated, "Low B/P and higher [sic] than normal." The report indicated the physician nor family was notified of the resident's change in condition at that time, but on 6/28/16 at 8:47 A.M.</p>		<p>timey</p> <p>What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not recur:</p> <ul style="list-style-type: none"> The licensed nurses will be re-educated on timely notification of physician and family for change of condition on or before 8/17/16 by the DNS/Designee The SBAR tool will also be utilized for any change of condition identified. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> The change of condition and physician notification QAPI tool will be utilized daily x 4 weeks, bi-weekly x 2 months, monthly x 3 and quarterly thereafter. Findings from the QAPI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practices above the 95% threshold. 	

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	<p>Progress Notes continued:</p> <p>6/26/16 at 7:30 P.M.: "Resting quietly in bed. When questioned, states feels ok. Skin is cool to touch, but dry. Only ate fruit for supper, but is drinking well. Has had no vomiting, but cont with watery stools per colostomy. VS [vital signs] 90/60, [temperature] 96.7, [pulse] 100...Lomotil, 2.5 mg 1 po [by mouth] for watery stools."</p> <p>6/26/16 at 1:13 A.M.: "Colostomy bad and flange [sic] changed as ordered. Resident stoma noted to be irritated from diarrheal (sic) stools noted earlier....Color pale skin warm and dry." A Vital Signs report at that time indicated the resident's temperature was 99.3.</p> <p>6/27/16 at 1:20 P.M.: "This nurse called to res room noted res to be cool and clammy. ABD [abdomen] hard and distended. No BS [bowel sounds] noted. Res had emesis x 1 this shift. Res has a nonproductive cough...Temp 100.1. [Name of physician] notified N.O. [new order] received may send to [name of hospital] ER for eval [evaluation] and treat...Message left for sister [name] awaiting return call."</p> <p>The resident was transferred to the hospital ER on 6/27/16 at 1:50 P.M.</p>			

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	<p>On 7/20/16 at 2:50 P.M., during an interview with the Director of Nursing (DON), she indicated she did speak to LPN # 4 regarding the resident's symptoms on 6/26/16. She indicated LPN # 4 told her that she notified the physician and family of the resident's symptoms, but there was not documentation of notification. .</p> <p>On 7/20/16 at 3:20 P.M., LPN # 1 was interviewed. LPN # 1 indicated she was the nurse working who send the resident to the ER on 6/27/16. She indicated the resident "could answer questions, but he had dementia, so didn't know how to say if he was feeling bad." LPN # 1 indicated she thought she was "the first one to notify the doctor" of the resident's symptoms.</p> <p>On 7/21/16 at 10:30 A.M., the Administrator provided the current facility policy on "Resident Change of Condition," dated 1/2015. The policy included: "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place...Any sudden or serious change in a resident's condition manifested by a marked change in</p>			

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	<p>physical or mental behavior will be communicated to the physician...The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. All nursing actions/interventions will be documented in the medical record as soon as possible after resident needs have been met...."</p> <p>This Federal tag relates to Complaint IN00204951.</p> <p>3.1-5(a)(2)</p>			

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F 0223 SS=D Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on interview and record review, the facility failed to ensure a resident remained free of physical abuse, in that a CNA held down a resident's hands while nursing staff attempted to administer medications, for 1 of 5 residents reviewed for abuse, in a sample of 18. Resident A</p> <p>Findings include:</p> <p>An Indiana State Department of Health (ISDH) report indicated the following: "Incident Date: 06/28/2016, Incident Time: 07:05 AM, Residents Involved: [Resident A]...Diagnosis:...Alzheimer's disease...Staff Involved: [LPN # 5], [Speech Therapist], [CNA # 1], [Speech Therapist student]...Brief Description of Incident: [Resident A] was refusing to take her morning medications this</p>	F 0223	<p>F-223 Jasper</p> <p>F-223 Free from Abuse/involuntary seclusion</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident A affected by the alleged deficient practice has been identified by the Interdisciplinary team and has had follow up for emotional and psychosocial distress with no negative outcomes identified.</p>	08/17/2016			

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	<p>morning. [LPN # 5] was attempting to give resident medication despite her refusals. [LPN # 5] asked [CNA # 1] to hold resident's hands so she could give resident her medication. Speech therapist [name], along with her speech therapist student [name], arrived near [Resident A] to watch how she was doing taking her medications. [Speech Therapist] stated she witnessed resident shaking her head in refusal of her medications. [CNA # 1] did as her charge nurse asked her to do and held the hands of the resident. [Speech Therapist] asked [LPN # 5] to stop attempting to give [Resident A] her medications. [Speech Therapist] asked twice before [LPN # 5] stopped trying. [Speech Therapist] explained to [LPN # 5] and [CNA # 1] the choking risk involved with attempting to give medications to a resistant resident...Preventive Measures Taken:...All employees will be re-educated on abuse policy and reporting of abuse allegations. All employees will be re-educated regarding resident's rights, including the right to refuse medications..."</p> <p>On 7/20/16 at 10:15 A.M., the Administrator provided an investigation into the incident with Resident A. A statement by CNA # 1 indicated, "Res [resident] wouldn't take her meds. [LPN</p>		<p>How will you identify other residents</p> <p>Having the potential to be affected by the same deficient practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice · Residents that are interviewable will be interviewed on or before 8/17/16 by the Customer Care Reps utilizing the QAPI form on abuse. – Any concerns received from interviews will be immediately addressed by the Executive Director and or Designee. <p>What measures will be put into place or what systemic changes you will make to ensure the deficient practice does not r</p> <ul style="list-style-type: none"> · Weekly resident interviews will be completed relating to abuse by Customer Care Reps · Staff will be educated on the abuse prohibition policy with emphasis on physical abuse on 	

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	<p># 5] asked [CNA # 1] to hold res hands down. [CNA # 1] did as her nurse asked but didn't hold too tight. [CNA # 1] was afraid of getting in trouble by not listening to her charge nurse. DNS [Director of Nursing Service] [and] UM [Unit Manager] explained it is OK to say no to charge nurse if she feels like what is being asked of her is wrong. LPN came to [CNA # 1] to tell her 'they're going tell [sic] on us' referring to ST [Speech Therapist]."</p> <p>An additional statement by the ST indicated, "ST wanted to see how res takes her meds. LPN asked CNA to hold res hands down. Res kept shaking her head. ST told LPN to stop as she kept trying to shove spoon in res mouth. LPN told ST 'don't write me up' over and over. ST cleaned res face. Told LPN twice to stop...."</p> <p>An additional statement by the ST student indicated, "Meds crushed and put in a cup. Tried to give to res. [Resident A] moved her head as to not take her meds. LPN kept scooping meds off res chin when she spit them out and pushed the meds back in her mouth. Asked CNA to hold res hands down and kept pushing/forcing res to take meds. ST asked LPN twice to stop due to choking risk. LPN stated she needs to take her</p>		<p>or before 8/17/16 by the DNS/designee.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <p>To ensure compliance the ED/designee is responsible for the completion of the Abuse Prohibition and Investigation-QAPI tool weekly times 4, bi-weekly x 2 months, monthly x 3 and quarterly thereafter. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Threshold of 100% I not achieved an action plan will be developed to ensure compliance (date)</p>		

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	<p>medicine. LPN acknowledged she had done the wrong thing."</p> <p>On 7/20/16 at 2:50 P.M., during an interview with the Director of Nursing (DON), she indicated that her investigation revealed that LPN # 5 was attempting to give medications to Resident A, and Resident A started swinging her hands. She indicated LPN # 5 asked CNA # 1 to hold the resident's hands, and she held them lightly. She indicated the ST and ST student witnessed the incident and informed the Social Services Director immediately. The DON indicated she felt as if LPN # 5 used poor judgment, and that she counseled her that it was against the resident's rights to force the medications upon her. She indicated LPN # 5 no longer worked at the facility, and that CNA # 1 was a part time "as needed" CNA.</p> <p>On 7/20/16 at 3:35 P.M., the Speech Therapist was interviewed. She indicated she had Resident A on her caseload, and wanted to observe how the resident did at breakfast. She indicated she saw that the nurse was going to give the resident her medications, and that the resident raised up her arm, "indicating no." She indicated [LPN # 5] asked the CNA to hold down the resident's arms so she</p>			

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	<p>could give her her medications. The ST indicated, "I tried to tell her to stop," but that the nurse indicated, "She needs her meds." The ST indicated the resident was shaking her head, and the ST told the nurse again, "Stop, that's not the way to do it."</p> <p>On 7/21/16 at 10:20 A.M., the ST student was interviewed. She indicated she had been working at the facility for a couple of months, and would be done with her schooling in a month. She indicated, "We saw a nurse giving the resident her medication - it was crushed in a pureed mix. The patient refused; she kept turning her face away and spat her medication out. The nurse asked a CNA to help her, and hold her hands down." She indicated the ST told the nurse not to do that; that the resident had a tendency to vomit, but the nurse stated the resident needed to take her medication.</p> <p>CNA was unavailable for interview during the survey process.</p> <p>On 7/20/16 at 10:00 A.M., the Administrator provided the current facility policy on "Abuse Prohibition, Reporting, and Investigation," dated July 2015. The policy included: "It is the policy of [name of corporation] to protect residents from abuse including physical</p>						

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F 0226 SS=D Bldg. 00	<p>abuse...Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment...."</p> <p>This Federal tag relates to Complaint IN00204951.</p> <p>3.1-27(b)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to ensure an abuse prohibition policy was implemented, in that a resident a CNA held down a resident's hands while nursing staff attempted to administer medications, for 1 of 5 residents reviewed for abuse, in a sample of 18. Resident A</p> <p>Findings include:</p> <p>An Indiana State Department of Health (ISDH) report indicated the following: "Incident Date: 06/28/2016, Incident Time: 07:05 AM, Residents Involved:</p>	F 0226	<p>F-226 jasper</p> <p>F-226</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p>	08/17/2016			

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	<p>[Resident A]...Diagnosis:...Alzheimer's disease...Staff Involved: [LPN # 5], [Speech Therapist], [CNA # 1], [Speech Therapist student]...Brief Description of Incident: [Resident A] was refusing to take her morning medications this morning. [LPN # 5] was attempting to give resident medication despite her refusals. [LPN # 5] asked [CNA # 1] to hold resident's hands so she could give resident her medication. Speech therapist [name], along with her speech therapist student [name], arrived near [Resident A] to watch how she was doing taking her medications. [Speech Therapist] stated she witnessed resident shaking her head in refusal of her medications. [CNA # 1] did as her charge nurse asked her to do and held the hands of the resident. [Speech Therapist] asked [LPN # 5] to stop attempting to give [Resident A] her medications. [Speech Therapist] asked twice before [LPN # 5] stopped trying. [Speech Therapist] explained to [LPN # 5] and [CNA # 1] the choking risk involved with attempting to give medications to a resistant resident...Preventive Measures Taken:...All employees will be re-educated on abuse policy and reporting of abuse allegations. All employees will be re-educated regarding resident's rights, including the right to refuse medications...."</p>		<ul style="list-style-type: none"> · Resident A affected by the alleged deficient practice has been identified by the Interdisciplinary team and has had follow up for emotional and psychosocial distress with no negative outcomes identified. · How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: · All residents have the potential to be affected by the alleged deficient practice · Residents that are interviewable will be interviewed on or before 8/17/16 by the Customer Care Reps utilizing the QAPI form on abuse. – Any concerns received from interviews will be immediately addressed by the Executive Director and or Designee. · Residents will also be asked questions utilizing the QAPI form on abuse during resident council meetings- with any concerns voiced will be immediately addressed by the Executive Director and or Designee, What measures will be put into 				

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	<p>On 7/20/16 at 10:15 A.M., the Administrator provided an investigation into the incident with Resident A. A statement by CNA # 1 indicated, "Res [resident] wouldn't take her meds. [LPN # 5] asked [CNA # 1] to hold res hands down. [CNA # 1] did as her nurse asked but didn't hold too tight. [CNA # 1] was afraid of getting in trouble by not listening to her charge nurse. DNS [Director of Nursing Service] [and] UM [Unit Manager] explained it is OK to say no to charge nurse if she feels like what is being asked of her is wrong. LPN came to [CNA # 1] to tell her 'they're going tell [sic] on us' referring to ST [Speech Therapist]."</p> <p>An additional statement by the ST indicated, "ST wanted to see how res takes her meds. LPN asked CNA to hold res hands down. Res kept shaking her head. ST told LPN to stop as she kept trying to shove spoon in res mouth. LPN told ST 'don't write me up' over and over. ST cleaned res face. Told LPN twice to stop...."</p> <p>An additional statement by the ST student indicated, "Meds crushed and put in a cup. Tried to give to res. [Resident A] moved her head as to not take her meds. LPN kept scooping meds off res</p>		<p>place or what systemic changes you will make to ensure the deficient practice does not reoccur?</p> <ul style="list-style-type: none"> Weekly resident interviews will be completed relating to abuse by Customer Care Reps Staff will be educated on the abuse prohibition policy with emphasis on physical abuse <p>by the DNS/designee on or before 8/17/16</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</p> <ul style="list-style-type: none"> To ensure compliance the ED/designee is responsible for the completion of the Abuse Prohibition and Investigation-QAPI tool weekly times 4, bi-weekly x 2 months, monthly x3 and quarterly thereafter. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Threshold of 100% I not achieved an action plan will be 	

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	<p>chin when she spit them out and pushed the meds back in her mouth. Asked CNA to hold res hands down and kept pushing/forcing res to take meds. ST asked LPN twice to stop due to choking risk. LPN stated she needs to take her medicine. LPN acknowledged she had done the wrong thing."</p> <p>On 7/20/16 at 2:50 P.M., during an interview with the Director of Nursing (DON), she indicated that her investigation revealed that LPN # 5 was attempting to give medications to Resident A, and Resident A started swinging her hands. She indicated LPN # 5 asked CNA # 1 to hold the resident's hands, and she held them lightly. She indicated the ST and ST student witnessed the incident and informed the Social Services Director immediately. The DON indicated she felt as if LPN # 5 used poor judgment, and that she counseled her that it was against the resident's rights to force the medications upon her. She indicated LPN # 5 no longer worked at the facility, and that CNA # 1 was a part time "as needed" CNA.</p> <p>On 7/20/16 at 3:35 P.M., the Speech Therapist was interviewed. She indicated she had Resident A on her caseload, and wanted to observe how the resident did at</p>		developed to ensure compliance (date)		

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	<p>breakfast. She indicated she saw that the nurse was going to give the resident her medications, and that the resident raised up her arm, "indicating no." She indicated [LPN # 5] asked the CNA to hold down the resident's arms so she could give her her medications. The ST indicated, "I tried to tell her to stop," but that the nurse indicated, "She needs her meds." The ST indicated the resident was shaking her head, and the ST told the nurse again, "Stop, that's not the way to do it."</p> <p>On 7/21/16 at 10:20 A.M., the ST student was interviewed. She indicated she had been working at the facility for a couple of months, and would be done with her schooling in a month. She indicated, "We saw a nurse giving the resident her medication - it was crushed in a pureed mix. The patient refused; she kept turning her face away and spat her medication out. The nurse asked a CNA to help her, and hold her hands down." She indicated the ST told the nurse not to do that; that the resident had a tendency to vomit, but the nurse stated the resident needed to take her medication.</p> <p>Two (2) messages were left with CNA # 1, but she did not return the calls.</p> <p>On 7/20/16 at 10:00 A.M., the</p>						

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F 0328 SS=G Bldg. 00	<p>Administrator provided the current facility policy on "Abuse Prohibition, Reporting, and Investigation," dated July 2015. The policy included: "It is the policy of [name of corporation] to protect residents from abuse including physical abuse...Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment...."</p> <p>This Federal tag relates to Complaint IN00204951.</p> <p>3.1-28(a)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p>	F 0328	F-328 jasper	08/17/2016			

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	<p>Based on interview and record review, the facility failed to assess a resident, with a colostomy, new symptoms of diarrhea, vomiting, and abnormal vital signs, resulting in a hospitalization for a small bowel obstruction, for 1 of 1 residents reviewed with colostomies, in a sample of 18. Resident B</p> <p>Findings include:</p> <p>The closed clinical record of Resident B was reviewed on 7/20/16 at 2:15 P.M. Diagnoses included, but were not limited to, dementia, congestive heart failure, and acute kidney failure.</p> <p>A resident Care Plan, initially dated 7/3/15 and updated 3/29/16, indicated, "Resident has an ostomy." The Approaches included: "Monitor BM's [sic], notify MD of abnormal findings."</p> <p>A Minimum Data Set (MDS) assessment, dated 4/1/16, indicated the resident scored a 3 out of 15 for cognition, with 15 indicating no memory impairment. The resident required extensive assistance of two + staff for toilet use. The MDS assessment indicated the resident "had an ostomy, or did not have a bowel movement for the entire 7 days."</p>		<p>F-328 Treatment/care for Special needs.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> · Resident B has passed away <p>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?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice, · Resident progress notes will be reviewed daily by the DNS/designee to identify change of condition documented with further review to ensure MD/family notifications were completed and timely <p>What measures will be put into place or what systemic changes</p>	

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	<p>A Vital Signs report, dated 6/14/16, indicated the resident's blood pressure was 120/68, pulse was 70, and temperature was 97.3.</p> <p>A Physician's Note, dated 6/21/16, indicated, "Tolerating colostomy - Continue with current meds/tx [treatments]..."</p> <p>Progress Notes included the following notations:</p> <p>6/26/16 at 1:53 A.M.: "Resident resting quietly at present. Resident had emesis [vomiting] earlier this shift x 1, will cont. to monitor. HOB [head of bed] elevated, no SOA [shortness of air] noted d/t Chronic Obstructive Pulmonary Disease." Documentation of vital signs, or an abdominal assessment, was not found in the clinical record.</p> <p>A Vital Signs report, dated 6/26/16 at 1:49 P.M., indicated the resident's blood pressure was 89/50, blood sugar was 243 "High," and pulse was 98.</p> <p>Progress Notes continued:</p> <p>6/26/16 at 1:54 P.M.: "Res. [resident] is not feeling good this day, he is cool and clammy, not eating, but is drinking well. He stated 'I feel O.K.' Blood sugar</p>		<p>will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> The licensed nurses will be re-educated on timely notification of physician and family for change of condition on or before 8/17/16 by the DNS/Designee The SBAR tool will also be utilized for any change of condition identified <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> The QAPI tool for change of condition and Physician notification will be utilized weekly x 4, bi-weekly x 2 months, monthly x 3 and quarterly thereafter. Findings from the QAPI process will be reviewed monthly and an action plan will be implemented for thresholds below 95%. 	

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	<p>running higher than normal and was given s/s [sliding scale] insulin as order. B/P [blood pressure] is running low. Place a cool cloth on res. head. Res. is alert to name, touch, and can answer questions appropriated [sic]."</p> <p>An "Event Report," dated 6/26/16 at 2:00 P.M., indicated, "Low B/P and higher [sic] than normal." The report indicated the physician was not notified of the resident's change in condition at that time.</p> <p>Progress Notes continued:</p> <p>6/26/16 at 7:30 P.M.: "Resting quietly in bed. When questioned, states feels ok. Skin is cool to touch, but dry. Only ate fruit for supper, but is drinking well. Has had no vomiting, but cont with watery stools per colostomy. VS [vital signs] 90/60, [temperature] 96.7, [pulse] 100...Lomotil, 2.5 mg 1 po [by mouth] for watery stools."</p> <p>6/26/16 at 1:13 A.M.: "Colostomy bad and flange [sic] changed as ordered. Resident stoma noted to be irritated from diarrheal stools noted earlier....Color pale skin warm and dry." A Vital Signs report at that time indicated the resident's temperature was 99.3.</p>			

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	<p>6/27/16 at 1:20 P.M.: "This nurse called to res room noted res to be cool and clammy. ABD [abdomen] hard and distended. No BS [bowel sounds] noted. Res had emesis x 1 this shift. Res has a nonproductive cough...Temp 100.1. [Name of physician] notified N.O. [new order] received may send to [name of hospital] ER for eval [evaluation] and treat...Message left for sister [name] awaiting return call."</p> <p>The resident was transferred to the hospital ER on 6/27/16 at 1:50 P.M.</p> <p>A hospital ER physician documentation note dated 6/27/16 at 2:40 P.M., indicated, "Chief Complaint: Abdominal Pain...presents to the emergency department today with some abdominal distention...does have a colostomy on the left side...Physical Exam:...Abdomen:...Abnormal bowel sounds. Distention with tympany to percussion...Not soft...Progress and Procedures...while in the emergency department the patient had a workup performed which showed a small bowel obstruction...Admitted to the Intensive Care Unit...Clinical Impression: small bowel obstruction, Sepsis, Hypotension [low blood pressure]."</p> <p>On 7/20/16 at 2:50 P.M., during an</p>			

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	<p>interview with the Director of Nursing (DON), she indicated she did speak to LPN # 4 regarding the resident's symptoms and lack of a thorough assessment on 6/26/16. She indicated LPN # 4 told her that she notified the physician and family of the resident's symptoms, but there was not documentation of notification. She indicated LPN # 4 told her that "people vomit and have diarrhea every day, and she didn't necessarily call the doctor every time." The DON indicated she educated staff that if a resident with a colostomy had watery stools, they needed to investigate the reason for them. She indicated LPN # 4 no longer worked at the facility.</p> <p>On 7/20/16 at 3:20 P.M., LPN # 1 was interviewed. LPN # 1 indicated she was the nurse working who send the resident to the ER on 6/27/16. She indicated the resident "could answer questions, but he had dementia, so didn't know how to say if he was feeling bad." LPN # 1 indicated she thought she was "the first one to notify the doctor" of the resident's symptoms. LPN # 1 indicated the resident's Lomotil was "an old order. It had not been used for a long time."</p> <p>This Federal tag relates to Complaint IN00204951.</p>			

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F 0425 SS=D Bldg. 00	<p>3.1-47(a)(3)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure</p>			

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	<p>the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on observation, interview, and record review, the facility failed to administer Tramadol, a medication ordered for pain, for 14 doses, due to the medication being unavailable from the pharmacy, for 1 of 14 residents reviewed during a medication pass, in a sample of 18. Resident D</p> <p>Findings include:</p> <p>On 7/20/16 at 12:05 P.M., LPN # 2 was observed during a medication pass to administer eye drops to Resident D.</p> <p>On 7/21/16 at 9:45 A.M., the clinical record of Resident D was reviewed. A Physician's order, initial date unknown, but on the July recertification orders, indicated, "Tramadol 50 mg [one] po [by mouth] TID [3 times daily] Dx [diagnosis] Chronic pain." The orders included the times for the medication to</p>	F 0425	<p>F-425jasper</p> <p>F-425 Pharmaceutical SVC Accurate Procedures, RPH</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident D's Tramadol is now available and is receiving per Physician order.</p> <p>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?</p>	08/17/2016

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	<p>be administered as 8:00 A.M., 12:00 P.M., and 6:00 P.M.</p> <p>Resident D's Medication Administration Record (MAR), dated July 2016, was reviewed at that time. The MAR indicated the resident had not received the Tramadol since 7/16/16 at 6:00 P.M. Entries on the back side of the MAR included: "7/17/16 Tramadol unavailable D/T [due to] no Rx [prescription] - MD aware. 7-20 Tramadol unavailable - D/T [no] Rx."</p> <p>LPN # 2 was interviewed at that time regarding the resident's Tramadol. She indicated, "From what I understand, the pharmacy is waiting on a hard script." LPN # 3 indicated at that time that the physician's office said they had sent a hard script, but the pharmacy indicated they did not have one. LPN # 2 indicated, "Some pharmacies will let you use an authorization code to obtain the medication out of the Emergency Drug Kit, but ours doesn't."</p> <p>On 7/21/16 at 10:45 A.M., the Administrator provided the current facility pharmacy policy, dated 2/14. The policy included: "Purpose: To define a process for ordering and dispensing controlled substance medications in a manner compliant with all State and</p>		<ul style="list-style-type: none"> · All residents receiving a controlled substance have the potential to be affected by the alleged deficient practice. · DNS/designee will complete an audit of all residents receiving a controlled substance and review for medication availability on or before 8/17/16. The Physician and Pharmacy will be notified immediately if a medication is found not to be available for resident per Physicians order. · All new controlled substance orders will be reviewed daily by the DNS/designee to ensure availability of medication. <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> · Licensed nurses were educated on or before 8/17/16 by the DNS/designee on medication availability for a controlled substance <p>How the corrective action(s) will be monitored to ensure the</p>				

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	<p>Federal laws, rules and regulations...All orders for controlled substances require a valid written prescription or verbal authorization...If a written prescription is not possible, the pharmacy may accept a verbal authorization...A pharmacist is available twenty-four (24) hours a day, seven (7) days a week to receive verbal authorizations...."</p> <p>This Federal tag relates to Complaint IN00204951.</p> <p>3.1-25(a)</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance the ED/designee is responsible for the completion of the Pharmacy Services-QAPI tool weekly times 4, bi-weekly x2 months, monthly x3 and quarterly thereafter. The results of these audits will be reviewed by the QAPI committee overseen by the ED. Threshold of 100% I not achieved an action plan will be developed to ensure compliance (date)</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2016
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	