

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/17/2015
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NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: September 9, 10, 11, 14, 15,16, and 17 2015</p> <p>Facility number: 004268 Provider number: 155735 AIM number: 200504460</p> <p>Census bed type: SNF: 11 SNF/NF: 39 Residential: 30 Total: 80</p> <p>Census payor type: Medicare: 12 Medicaid: 24 Private: 44 Total: 80</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 30576 on September 24, 2015.</p>	F 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by 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 provisions 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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F 0226 SS=D Bldg. 00	<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 a staff member received on-going/annual abuse inservice education timely for 1 of 11 staff members reviewed for abuse inservice education. (CNA #3)</p> <p>Findings include:</p> <p>The Employee Records for CNA #3 were reviewed on 9/17/15 at 2:00 p.m. The Employee Records form indicated CNA #3's start date was 7/10/13.</p> <p>The employee personnel file for CNA #3 included verification of initial training for abuse on 7/10/13.</p> <p>The Director of Health Services provided, on 9/17/15 at 11:00 a.m., the Time &amp; Attendance-Employee Punch History for CNA #3, and it indicated CNA #3 worked in the facility 96 days since March 2015.</p>	F 0226	<p>F226 1. CNA#3 was contacted and verbally counseled and discussed the facility abuse and expectations of excellence. 2. All residents have potential to be affected by this practice. Facility will ensure that staff members will complete annual/mandatory training to include but not limited to abuse. Facility to complete in-servicing by October 17, 2015. 3. Facility to ensure that in-services are update and monitored regularly by the In-service Director. In-service director to monitor weekly for employees out of compliance. 4. In-service Director/Designee to monitor weekly X 4 weeks, twice monthly X 3 months, and then monthly throughout next review. Findings to be reported to Executive Director/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in</p>	10/17/2015

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F 0242 SS=D Bldg. 00	<p>During an interview with the Business Office Manager, on 9/17/15 at 11:24 a.m., she indicated abuse training was to be completed annually.</p> <p>On 9/17/15, at 1:30 p.m., the DHS indicated the facility was unable to locate verification for on-going/annual abuse training for CNA #3, since the training/in-services listed above.</p> <p>A policy titled, Abuse and Neglect Procedural Guidelines, dated 9/16/11, was received from the Administrator on 9/9/15 at 2:00 p.m. The policy indicated, "...b. Training i. Provide training for new employees through orientation and with ongoing training programs....ii. Documentation of training of [name of company] employees will be maintained with in-service records in the campus..."</p> <p>3.1-28(a)</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,</p>	F 0242	<p>compliance by date of certain: 10/17/2015.</p> <p>F242 1. Resident #53's care plan was immediately updated to</p>	10/17/2015			

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	<p>the facility failed to seek and honor a resident's preference for waking up in the morning for 1 of 3 residents reviewed for choices. (Resident #53)</p> <p>Findings include:</p> <p>The clinical record for Resident #53 was reviewed on 9/10/15 at 2:00 p.m. The diagnoses for Resident #53 included, but were not limited to osteoporosis and rheumatoid arthritis.</p> <p>The 6/7/15 Quarterly MDS (minimum data set) Assessment indicated Resident #53 required extensive assistance of one person for transfers, locomotion on unit, dressing, toilet use, and personal hygiene. It indicated she had a BIMS (brief interview for mental status) score of 12, indicating the resident was cognitively in tact.</p> <p>An interview was conducted with Resident #53 on 9/10/15 at 11:32 a.m. She indicated she did not choose when to get up in the morning. She indicated she got up anywhere from 6:15 a.m., to 8:30 a.m. She indicated she would like to get up at 6:15 a.m., or 6:30 a.m. She indicated the facility was aware she'd like to get up by 6:30 a.m. She indicated that morning (of 9/10/15) she got up at 8:15 a.m.</p>		<p>reflect that the resident prefers to wake at or before 6:30 AM. Care plan updates will be available for all staff to review in the resident profile in care tracker. 2. All residents have potential to be affected by this practice. Facility to implement use of "Personal Preference Form". Facility to in-service staff members on "Guidelines for Resident Personal Preferences and Profile." 3. Facility to ensure that "Personal Preference Form" is complete for all current and future residents. Resident Preferences to be discussed during Resident First Meetings. All forms to be completed by date of certain: 10/17/2015. 4. Unit Manager to ensure that resident preferences are discussed during the Resident First Meetings. Unit Manager to monitor weekly X 4 weeks, twice monthly X 3 months, and then monthly throughout next review. Findings to be reported to Director of Health Services/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>	

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	<p>An interview was conducted with the Administrator on 9/14/15 at 11:12 a.m. She indicated the determination of what time a resident was assisted to get up in the morning and to bed at night was discussed with the resident upon admission, documented on a preferences sheet, and annually on their activity assessment.</p> <p>An interview was conducted with the Activity Director on 9/14/15 at 2:24 p.m. She indicated the preferences assessment was filled out upon admission, upon a significant change in a resident's condition, and annually. She indicated the assessment asked about sleep patterns, so if a resident specified a time, that's where it would be documented.</p> <p>Resident #53's 3/17/15 annual Life Enrichment Assessment indicated it was very important for her to choose her own bedtime. It did not indicate how important it was to choose her own wake up time and did not indicate a specific wake up time preference.</p> <p>An interview was conducted with the Director of Health Services (DHS) on 9/14/15 at 3:00 p.m. He indicated the facility would know what time to assist a resident to get up in the morning if the</p>			

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	<p>resident or family told them. He indicated he knew a resident's time preference for waking up in the morning was discussed on admission and probably during care plan meetings.</p> <p>An interview was conducted with Resident #53 on 9/17/15 at 11:35 a.m. She indicated she did not get to breakfast that day until after 8:00 a.m. She indicated no one at the facility asked her what time she'd like to wake up, and didn't think she'd ever told anyone at the facility what time she'd like to get up.</p> <p>An interview was conducted with CNA #10 on 9/17/15 at 11:45 a.m. She indicated she assisted Resident #53 up that morning (of 9/17/15) around 7:45 a.m. She indicated they typically tried to get to her earlier so she could eat breakfast with (name of another resident), because they were bff's (best friends forever). She indicated they were unable to get Resident #53 to breakfast that morning before (name of another resident) left the dining room.</p> <p>An interview was conducted with LPN #11 on 9/17/15 at 11:44 a.m. She indicated she assisted Resident #53 up the morning of 9/16/15 between 7:00 a.m., and 7:30 a.m.</p>			

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	<p>An interview was conducted with Resident #53 on 9/17/15 at 11:52 a.m. She indicated she liked to get to breakfast before (name of another resident) left the dining room, but wasn't able to do that very often in the last 2 to 3 months, and would like to get up earlier.</p> <p>An interview was conducted with the DHS on 9/17/15 at 12:25 p.m. He indicated Resident #53's time preference to wake up in the morning should be included in her care plan. At this time, the DHS reviewed Resident #53's care plan and indicated he did not see that information in her care plan. He indicated Resident #53 typically did not tell them if anything was wrong, that any problems with care could be brought up in a care plan meeting, and considered a problem with wake up time a problem with care. He indicated this was the first time he'd heard she had a problem with the time she woke up in the morning. He indicated if Resident #53 was specifically asked what time she wanted to get up in the morning, she would tell them.</p> <p>The Guidelines For Resident Personal Preferences and Profile policy was provided by the DHS on 9/15/15 at 10:53 a.m. It indicated, "1. The Nursing Staff shall discuss the resident's preference for sleep/wake times and bathing as part of</p>			

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F 0282 SS=D Bldg. 00	<p>the admission assessment process. 2. This information shall be used to wake the resident in the morning, assist them to bed in the evening, medication administration times, meals and therapy treatments....4. All activity staff shall be trained to gather preference data. 5. The resident preferences and other care plan interventions shall be entered into the Resident Profile in the Care Tracker system by a member of the nursing leadership team for communication to nursing assistants....8. The preferences shall be included in the resident's plan of care to ensure it is reflective of their interests and choices."</p> <p>3.1-3(u)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to obtain a daily manual blood pressure as ordered by a physician for 1 of 5 residents' reviewed for unnecessary medications. (Resident #57)</p> <p>Findings include:</p>	F 0282	F282 1. Resident #57 was assessed by LPN at approximately 3:00 PM on September 16,2015 by LPN. It was noted that there were no adverse effects noted as a result of the resident receiving the medication as ordered. 2. All residents have potential to be effected by this practice. Nurses all verbally counseled September 17, 2015 during huddle. 3.	10/17/2015

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	<p>The clinical record for Resident #57 was reviewed on 9/14/15 at 11:17 a.m. The diagnoses for Resident #57 included, but were not limited to, chronic headaches and hypertension.</p> <p>A physician order dated, 10/23/14 indicated Resident #57's blood pressure was to be taken manually every day, and the physician was to be notified if the systolic blood pressure was greater than 160.</p> <p>The "Blood Pressure Monitoring Record" dated, July 2015, indicated no blood pressure readings for the following dates: July 6, July 9, July 10, July 14, and July 25, 2015.</p> <p>The "Blood Pressure Monitoring Record" dated, August 2015, indicated no blood pressure readings for the following dates: August 5, August 6, August 26, and August 31, 2015.</p> <p>The "Blood Pressure Monitoring Record" dated, September 2015, indicated no blood pressure reading for September 3rd. The last review date of this record was September 16th.</p> <p>An interview was conducted with the Director of Health Services on 9/16/15 at 2:00 p.m. He indicated he was unable to</p>		<p>Nurse Managers to monitor Blood Pressure Monitoring Records regularly. Nursing staff to be re-educated on the Medication Administration Guidelines by 10/17/2015. 4. Nurse Managers to monitor "Blood Pressure Monitoring Record" twice weekly X 4 weeks, twice weekly X 3 months, and then monthly throughout next review. Findings to be reported to Director of Health Services/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>	

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F 0323 SS=E Bldg. 00	<p>located the remaining missing blood pressures. He indicated the blood pressures were not done.</p> <p>3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure water temperatures did not exceed 120 degrees Fahrenheit and to transfer a resident in accordance with her care plan for 8 of 50 residents in the facility (Residents #7, 19, 38, 42, 46, 48, 53, and 83)</p> <p>Findings include:</p> <p>1. On 9/9/15, at 3:00 p.m., water temperatures were taken at the restroom sinks of the following residents at the following temperatures: Residents #83 and #38 - 122 degrees Fahrenheit, Residents #42 and #19 - 122 degrees Fahrenheit, Residents #46 and #48 -122.9 degrees Fahrenheit, and Resident #7- 125.6 degrees Fahrenheit.</p>	F 0323	<p>F323 1. Elevated Water Temperatures: a. Director of Health Services reviewed skin assessments. Upon review of resident (#83, #38, #42, #19, #46, #48, #53, and #7) skin assessments, on September 9, 2015 there were no noted injuries as a result of elevated water temperatures that were documented. Improper Transfer b. Director of Health Services ensured safety of resident #53 by visually assessing resident and reviewed clinical record. Resident #53 also interviewed by the Executive Director. 2. All residents have potential to be effected by this practice. a. Director Plant Operations verbally counseled by Executive Director regarding importance of recording and reporting accurate water temperature randomly throughout the day. b. CNA #3 was in-serviced on using mechanical</p>	10/17/2015

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	<p>An interview was conducted with the DPO (Director of Plant Operations) and ADPO (Assistant Director of Plant Operations) on 9/9/15 at 3:20 p.m., in the boiler room. The DPO indicated water temperatures were taken daily on each hall. At this time the mixing valve was observed with the ADPO. The ADPO indicated the mixing valve read 130 degrees Fahrenheit. He indicated it read 115 that morning. The DPO indicated water temperatures were obtained between 8:00 a.m., and 10:00 a.m., when the most water is being used. The DPO indicated they needed to do a better job on taking water temperatures throughout the day, when water is at full flow.</p> <p>An observation of Resident #7's restroom sink water temperature was made with the ADPO on 9/9/15 at 3:32 p.m. It read 130.6 degrees Fahrenheit.</p> <p>On 9/9/15 at 3:40 p.m., an interview was conducted with Family Member #12, Resident #7's son and Power of Attorney who was visiting Resident #7 at the time the 130.6 degree water temperature was taken. He indicated Resident #7 used the restroom on her own and could turn the water on at the sink on her own as well. He indicated he'd seen her do it.</p> <p>An observation of Resident #7's restroom</p>		<p>lifts and interviewed regarding incident. LPN #14 was also counseled on Accident and Incident Reporting Guidelines. Nursing staff to be checked-off by super-user with return demonstration of proper use of the mechanical lifts. 3. Elevated Water Temperatures a. Director of Plant Operations (DPO) to monitor temps on a daily basis randomly. Temperatures to be recorded on temperature log. Improper Transfer b. Nurse managers to observe transfers on a random basis to ensure facility protocol is followed. 4. Elevated Water Temperatures a. Water temperatures to be also monitored as part of the Weekend Manager on Duty (off tour hours) duties on a regular basis. Water temperatures to be reported to Executive Director/Designee regularly throughout next review. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. Improper Transfer b. Nurse managers will observe transfer with use of mechanical lifts twice weekly X4 weeks, twice monthly X 3 months, and then monthly throughout next review. Findings to be reported to Director of Health Services/Designee. Findings will</p>		

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	<p>sink water temperature was made with the DPO on 9/9/15 at 3:51 p.m. The DPO's thermometer read 132 degrees Fahrenheit, then went down to 117 degrees Fahrenheit within the same water flow. He indicated they were not required to obtain water temperatures at a specific time.</p> <p>An interview was conducted with the Administrator on 9/9/15 at 4:10 p.m. She indicated, in her opinion, the water temperature in Resident #7's restroom was a safety concern because Resident #7 was cognitively impaired.</p> <p>An interview was conducted with the Campus Support Plant Operations on 9/11/15 at 10:00 a.m. He indicated he found the boiler was set too high, and thought the facility was down to the right water temperatures. He indicated the mixing valve was now set to 116 degrees Fahrenheit. He indicated the boilers, both heat exchangers, and the mixing valve had to be adjusted.</p> <p>On 9/14/15 at 11:18 a.m. the Administrator provided a copy of page 57 of the Indiana Administrative Code and indicated this was used by the facility to guide water temperatures. It indicated, "Water temperature at point of use must be maintained between one hundred</p>		<p>be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>				

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	<p>(100) degrees Fahrenheit and one hundred twenty (120) degrees Fahrenheit."</p> <p>2. The clinical record for Resident #53 was reviewed on 9/10/15 at 9:00 a.m. The diagnoses included, but were not limited to osteoporosis and rheumatoid arthritis.</p> <p>The 6/7/15 Quarterly MDS (minimum data set) Assessment for Resident #53 indicated she required extensive assistance of one person for transfers</p> <p>An interview was conducted with Resident #53 on 9/10/15 at 11:36 a.m. She indicated CNA #3 put her to bed one night by picking her up by her arms. She indicated it hurt, and she had a bruise on her arm for a week. She indicated CNA #3 knew she (Resident #53) required a lift to be transferred, but said she could do it. Resident #53 indicated CNA #3 probably could have done it, if she (Resident #53) didn't have "severe" rheumatoid arthritis and osteoporosis. She indicated the facility knew about this incident, and it happened about 3 months ago.</p> <p>The 7/31/15 Other Skin Impairment Assessment indicated Resident #53 had a bruise on her left, upper arm that was 5</p>			

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	<p>cm x 1 cm. It indicated on 8/12/15 the bruise was resolved.</p> <p>Resident #53's 7/31/15 Nurse's Note, written by LPN #14, indicated, "Resident complained off (sic) pain in left arm. Observed a 5 cm x 1 cm bruise on left arm. Resident stated she did not know how she got the bruise. Called to (name of physician's office). Monitor bruise for any changes."</p> <p>An interview was conducted with the Administrator on 9/10/15 at 11:55 a.m. She indicated she didn't have any incidents regarding CNA #3, but she would look into it.</p> <p>The 9/15/15 Follow Up Incident Report for Resident #53 was provided by the Administrator on 9/16/15 at 12:57 p.m. It indicated, on 9/10/15, it was brought to the facility's attention that Resident #53 was inappropriately transferred by a staff member and received a bruise on her left upper arm during the transfer, which lasted approximately a week. Upon facility review of Resident #53's clinical record, it was identified that Resident #53 complained of pain in her left arm, where a 5 cm x 1 cm bruise was observed on 7/31/15, but she did not know how she got the bruise. The Follow Up Incident Report indicated, "It should be noted that</p>			

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	<p>this resident was at that time, a "Sit to Stand" lift, therefore the area on the outer aspect of the arm could have been related to the placement of the left pad. The resident identified (name of CNA #3) as the individual that had transferred her without appropriate lift. The staff member was interviewed, counseled, and re-educated on appropriate use of the lift equipment...The nurse who identified the area of skin impairment was also counseled on Accident and Incident Reporting Guidelines....Upon review of investigation the resident stated that she had received the bruise during an inappropriate (without lift) transfer. Resident had mentioned that she didn't report the transfer initially as the cause of the bruise to avoid getting an employee in trouble...."</p> <p>The 9/11/15 CNA #3 Employee Counseling Record Form indicated CNA #3 was counseled regarding not following company policy for transferring residents safely, in that she attempted to transfer a resident without the use of a lift, which could have contributed to the resident acquiring a bruise of unknown origin.</p> <p>The 9/11/15 CNA #3 written statement indicated, "I (name and title of CNA #3), did transfer (name of Resident #53) without lift once with no injury and</p>			

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F 0329 SS=D Bldg. 00	<p>proper technique."</p> <p>The 9/11/15 LPN #14 written statement indicated, "On 7/31/15, employee stated that she transferred the resident without the lift. The resident when questioned said that she did not (sic) how it happened (sic)."</p> <p>An interview was conducted with the Administrator and DHS (Director of Health Services) on 9/16/15 at 1:51 p.m. The DHS indicated they determined Resident #53's bruise on her arm could have come from the improper transfer, the lift, and/or her medication.</p> <p>3.1-19(c) 3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>			

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	<p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to administer a resident's medication as ordered, ensure non-pharmacological interventions were attempted prior to administration of as needed anti-anxiety medication, and to address a gradual dose reduction of an anti-psychotic medication for 3 of 5 residents reviewed for Pre-Admission Screening/Resident Review and unnecessary medications (Residents #14 and #46, and #81).</p> <p>Findings include:</p> <p>1. a) The clinical record for Resident #46 was reviewed on 9/10/15 at 11:03 a.m. The diagnoses for Resident #46 included, but were not limited to, edema.</p> <p>The September, 2015 Physician's Orders for Resident #46 indicated to give a 40 mg tablet of Furosemide every Monday,</p>	F 0329	F329 1. Medication Error a. It was noted that resident #46 didn't receive Furosemide daily as it appeared per documentation. Doctor was notified that the resident received two additional doses of the listed medication. Medication error circumstance form completed at this time. Nursing staff obtained order to obtain labs to ensure that resident was not harmed as a result of the medication error. Medication Administration Record (MAR) was corrected to simplify and make it clear that the medication was to be administered Monday, Wednesday, and Friday. Resident #46 was assessed by the Director of Health Services and it was determined that there were no signs or symptoms noted that would indicated any adverse effects of receiving the medications. Resident #46's blood pressure order was changed from daily to weekly with an order to clarify the previous pharmacy recommendation. b.	10/17/2015

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	<p>Wednesday, and Friday for edema, effective 2/1/15.</p> <p>The September, 2015 MAR (medication administration record) indicated the Furosemide was given everyday from 9/1/15 to 9/15/15.</p> <p>On 9/15/15 at 1:45 p.m., an interview was conducted with LPN #12, whose initials were on the MAR for the Tuesday, 9/15/15 administration of Furosemide. She indicated she gave the administration of Furosemide that morning (of 9/15/15) to Resident #46. She indicated she was unaware the order was for Monday, Wednesday, and Friday only. She indicated they normally put x's on the MAR on the days a resident was not supposed to get a medication. There were no x's on Tuesdays, Thursdays, Saturdays, and Sundays on the MAR.</p> <p>An interview was conducted with the DHS (Director of Health Services) on 9/16/15 at 10:00 a.m. He indicated, based on the days Resident #46 received the Furosemide, she did receive 2 additional doses. The pill card for Resident #53's Furosemide was observed with the DHS at this time. It had 4 pills missing and 2 left. The pill card indicated to give on Monday, Wednesday, and Friday. It indicated the</p>		<p>MD notified regarding that Resident #14 received a dose of a PRN medication with no non-pharmalogical interventions documented. Gradual Dose Reduction A. Resident # 81 to be see by facility psychiatrist during next visit to facility. 2. All residents have the potential to be affected by this practice. Nursing staff to be re-educated on the Medication Administration policy. Nursing staff to be educated regarding the PRN Medication Administration. Nursing staff to be educated on Psychotropic Medication Usage and Gradual Dose Reductions (GDR). All education to be completed by 10/17/2015. 3. Nurse Managers to monitor Blood Pressure Monitoring Records regularly. Nurse managers also to ensure that orders not given daily will be clearly marked according on the MAR to ensure that the resident receives the medication as ordered. Clinical team (Director of Health Services, Assistant Director of Health Services, Unit Manager LPN, Medical Records LPN, MDS LPN, and Social Services Director BSW) to ensure that GDRs are completed as appropriately indicated. 4. Medication Monitoring a. Nurse Managers to monitor "Blood Pressure Monitoring Record" weekly X 4 weeks, twice monthly X 3 months, and then monthly throughout next review. Findings</p>	

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	<p>medication was filled 9/9/15. The DHS indicated the Furosemide was probably received by the facility on 9/10/15, and since there were only 2 pills left on 9/15/15, indicating she received 4 doses, it could be concluded only 2 additional doses were given.</p> <p>The 9/1/13 Specific Medication Administration Procedures policy was provided by the DHS on 9/16/15 at 8:58 a.m. It indicated, "Read medication label three (3) times: 1) prior to removing the medication package/container from the cart/drawer; 2) prior to removing the medication from the package/container; 3) as the package/container is returned to the cart/drawer. Compare label to MAR."</p> <p>b) The clinical record for Resident #46 was reviewed on 9/10/15 at 11:03 a.m. The diagnoses for Resident #46 included, but were not limited to: hypertension.</p> <p>The September, 2015 Physician's Orders for Resident #46 indicated to give a 12.5 mg tab of Carvedilol twice daily (upon rising and at night) and to hold for a systolic blood pressure less than 110. It indicated to give half of a 25 mg tablet of Hydralazine twice daily (upon rising and at night) and to hold for a systolic blood pressure less than 110.</p>		<p>to be reported to Director of Health Services/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. Gradual Dose Reductions b. Clinical Team Members as indicated above will monitor/discuss resident behaviors on a regular basis through facility Clinically At Risk (CAR) meetings. Behavioral concerns to be documented on CAR notes and discussed during Clinical Care Meetings (CCM). Behavioral concerns also will be reviewed by (Clinical Team, MD and/or NP) to determine if a GDR is supported (successful GDR) or not supported (failure) to promote the useage of the least dose possible to protect the well-being of the residents. GDR tracking to be completed by monthly pharmacy review. GDR review to be completed by Director of Health Services monthly throughout next review. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>		

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	<p>The September 2015 MAR (medication administration record) indicated the above medications were administered twice daily upon rising from 9/1/15 to 9/15/15 and twice daily at night from 9/1/15 to 9/14/15. The September, 2015 MAR and September, 2015 Blood Pressure Monitoring Record for Resident #46 indicated no blood pressures were obtained for Resident #46 thus far in the month of September, 2015.</p> <p>On 9/15/15 at 1:45 p.m., an interview was conducted with LPN #12, the nurse who administered the Carvedilol and Hydralazine to Resident #46 the morning of 9/15/15. She indicated she did not take Resident #46's blood pressure prior to administration of the medications that morning (of 9/15/15). She indicated if she did, she would write it down on her blood pressure log.</p> <p>An interview was conducted with the DHS on 9/16/15 at 10:00 a.m. He indicated he could not find an order to stop Resident #46's daily blood pressures, but there was a pharmacy recommendation in May, 2015 to stop the daily blood pressures and change to weekly. He indicated it did not look like the facility was obtaining daily or weekly blood pressures for Resident #46.</p>			
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	<p>The 9/1/13 Specific Medication Administration Procedures policy was provided by the DHS on 9/16/15 at 8:58 a.m. It indicated, "Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration."</p> <p>2. The clinical record for Resident #14 was reviewed on 9/15/15 at 11:15 a.m. The diagnoses for Resident #14 included, but were not limited to, anxiety and depression according to a Mood and Behaviors Care Plan dated 8/28/15.</p> <p>The August 2015 Physician's Orders indicated an order for clonazepam (anti-anxiety medication) 0.5 mg (milligrams) to given as needed (PRN) 3 times daily and an order for clonazepam 0.5 mg scheduled to be given twice daily.</p> <p>The August 2015 MAR indicated PRN clonazepam 0.5 mg was given on the following days: 8/3/15, 8/7/15, 8/17/15 &amp; 8/21/15.</p> <p>Non-pharmacological approaches were not located in the clinical record prior to the PRN medication administration on the above dates.</p> <p>During an interview with the Social Services Director (SSD), on 9/15/15 at</p>			

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	<p>1:00 p.m., she indicated it was the facility policy to attempt non-pharmacological approaches prior to PRN administration of anti-anxiety medication. The SSD further indicated she will further look into non-pharmacological approaches on the above dates.</p> <p>On 9/15/15, at 3:15 p.m., the SSD indicated the facility was unable to locate verification that non-pharmacological approaches were attempted prior to the administration of clonazepam on the above dates.</p> <p>A policy titled, Psychotropic Medication Usage and Gradual Dose Reductions, dated 8/2013, was received from the SSD, on 9/15/15 at 2:03 p.m. The policy indicated, "...9. Non-pharmacological interventions (such as behavioral interventions) are to be considered and used when indicated, instead of or in addition to, medications. a. Attempted non-pharmacological intervention will be documented on the PRN Medication Administration Form."</p> <p>3. The clinical record for Resident #81 was reviewed on 9/15/15 at 10:15 a.m. The diagnoses for Resident #81 included, but were not limited to, schizophrenia, history of sepsis, and history of rhabdomyolysis according to the</p>			

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	<p>September 2015 MAR (medication administration record).</p> <p>The September MAR indicated Resident #81 had an Physician's Order for Haloperidol Dec (anti-psychotic) 70 mg (milligrams) to be injected every 4 weeks since Resident #81 admitted to the facility on 7/25/14.</p> <p>A Nurse Practitioner Visit Note, dated 6/9/15, indicated, "...Pt [Patient] seen today for acute visit to evaluate report of [symbol for increase] anxious behaviors at night....1) Anxiety-[symbol for no increase; symbol for no changes]....Haldol Dec 70 mg IM [intramuscular] Q4wks [every 4 weeks] (schizophrenia)...."</p> <p>A Note to Attending Physician/Prescriber from the Pharmacist, dated 7/29/15, indicated, "...[name of resident #] has been receiving Haldol....since 7/2014. It is time to evaluate his medication to ensure he is receiving the lowest effective dosage to manage his symptoms....No [symbol for changes]-stable [was handwritten by the Physician]"</p> <p>No other documentation was located in the clinical record to indicate a GDR [gradual dose reduction] was considered besides the Note to Attending</p>			

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	<p>Physician/Prescriber since the initiation of the medication on 7/25/14.</p> <p>During an interview with the Social Services Director (SSD), on 9/15/15 at 1:00 p.m., she indicated the facility did not consider/address a GDR for the haldol, prior to 7/29/15.</p> <p>A policy titled, Psychotropic Medication Usage and Gradual Dose Reductions, dated 8/2013, was received from the SSD on 9/15/15 at 2:03 p.m. The policy indicated, "...Purpose: To ensure every effort is made for residents receiving psychoactive medications obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team....3. Efforts to reduce dosage or discontinue psychotropic medications will be ongoing, as appropriate. 4. A gradual dose reduction (GDR) will be attempted for two (2) separate quarters with at lease one month between attempts) per the physician's recommendation. Gradual dose reduction must be attempted annually thereafter, unless medically contraindicated....6. Gradual dose reductions will be documented on the GDR Circumstance form. The circumstance form will be filed in the</p>			

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F 0425 SS=D Bldg. 00	<p>assessment section of the medical records...."</p> <p>3.1-48(a)(6) 3.1-48(b)(2)</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 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. Based on observation, interview, and record review, the facility failed to discard expired insulin prior to administration for 1 of 6 residents who received insulin from the 100 hall medication cart. (Resident #75)</p> <p>Findings include:  During an observation of the 100 Hall</p>	F 0425	F425 1. Expired insulin was properly disposed of and new insulin was opened and dated appropriately. LPN #2 was verbally counseled on insulin expirations. 2. All residents have potential to be affected by this practice. Nursing staff to be educated on insulin expirations by 10/17/2015. 3. Nurse manager to monitor for expired medications in med carts. 4.	10/17/2015

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F 0441	<p>Medication Cart with LPN #2, on 9/16/15 at 11:10 a.m., a Lantus (insulin) flexpen 100 units/milliliter was observed with an open date of 8/8/15, for Resident #75.</p> <p>During an interview with LPN #2, on 9/16/15 at 11:12 a.m., LPN #2 indicated the Lantus flexpen was opened on 8/8/15 according to the label. LPN #2 further indicated the Lantus must've been used the previous night for Resident #75, since it was the only available Lantus flexpen in the medication cart for Resident #75.</p> <p>On 9/16/15 at 11:17 a.m., the Director of Health Services (DHS) indicated insulin usually expired within 28-30 days of the open date.</p> <p>The September 2015 MAR (medication administration record) indicated Resident #75 received Lantus on the following days: 9/7/15, 9/8/15, 9/9/15, 9/10/15, 9/11/15, 9/12/15, 9/13/15, 9/14/15, &amp; 9/15/15.</p> <p>A policy titled, Expiration Dates, no date, was received from the DHS on 9/16/15 at 1:37 p.m. The policy indicated, Lantus pens expire after, "...28 days...."</p> <p>3.1-25(o)</p>		<p>Nurse manager to check med cart weekly X 4 weeks, twice monthly x 3 months, and then monthly throughout next review. Findings to be reported to Director of Health Services/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>				
	483.65						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/17/2015
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SS=D Bldg. 00	<p><b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to</p>	F 0441	F441 1. QMA #1 was educated on proper cleaning procedures of the glucometers per manufacturer	10/17/2015	

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	<p>properly disinfect a glucometer (machine used for readings of blood glucose/sugar levels) during random observations for 1 of 2 residents observed for blood sugar testing. (Resident #27)</p> <p>Findings include:</p> <p>During an observation of QMA #1, on 9/14/15 at 11:53 a.m., QMA #1 completed blood glucose testing on Resident #75. QMA #1 took the glucometer (blood glucose machine) to the medication cart and wiped the glucometer with the [name of company] Bleach Germicidal Disposable Wipe for 15 seconds. QMA #1 put the glucometer on the medication cart and walked away to locate manufacturer's instructions for the [name of company] Bleach Germicidal Disposable Wipes. The glucometer dried within a minute and half. QMA #1 returned and QMA #1 indicated she was unable to locate manufacturer's instructions for the [name of company] Bleach Germicidal Disposable Wipes. QMA #1 then proceeded to Resident #27's room with the glucometer. QMA #1 wiped Resident #27's finger with an alcohol pad, pricked Resident #27's finger and placed the glucometer on Resident #27's lap while the glucometer was calculating the blood glucose measurement. After the blood</p>		<p>guidelines of wipes. 2. All residents have potential to be affected by this practice. Nursing staff to be educated on facility glucometer cleaning policy. All residents to assigned individual glucometers. 3. Nurse managers to ensure that each residents has individual glucometer. Nurse manager to monitor cleaning of glucometer. 4. Nurse managers to monitor weekly for 4 weeks, twice monthly X 3 months, and monthly throughout next review. Findings to be reported to Director of Health Services/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>	

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	<p>glucose measurement was obtained, QMA #1 took the glucometer back to the medication cart.</p> <p>During an interview with QMA #1 and LPN #2, on 9/14/15 at 12:15 p.m., LPN #2 indicated there were supposed to be "instructions" in front of the Medication Book on each medication cart and she further indicated she usually wiped the machine for 2 minutes and let it dry. QMA #1 indicated she did not see any instructions in her Medication Book and wasn't sure how long to wipe/disinfect the glucometer. LPN #2 then located the "instructions" in the 300 Hall Medication Book and the document LPN #2 provided was titled, "Skills Checklist Glucometer Machine."</p> <p>The Skills Checklist indicated, "...Cleans Glucometer surface after each use with a [name of company] wipe....Place glucometer on clean (tissue /paper towel) and allows to air dry for at least 3 minuted [sic] before using on another resident..." There was no instructions/checklist in the 100 hall Medication Book.</p> <p>The manufacturer's instructions for the [name of company] Bleach Germicidal Disposable Wipes, dated 2014, was provided by the Director of Health</p>			

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	<p>Services (DHS), on 9/14/15 at 12:35 p.m. The instructions indicated, "...3b. In the absence of heavy soil, take a clean wipe and thoroughly wet surface for a full four (4) minutes to disinfect. 4. Treated surface must remain visibly wet for a full four (4) minutes.* Use additional wipes(s) if needed to assure continuous four (4) minute wet contact time. Allow to air dry.... *Please note, what looks visibly wet on one surface type may look different on another surface type. Evaporation rates are affected by room humidity, temperature, and air flow. There factors must be taken into consideration when following label directions...."</p> <p>On 9/14/15 at 12:35 p.m., the DHS indicated according the manufacturer's instructions the glucometer should remain visibly wet for 4 minutes. The DHS further indicated he was unsure where the statement, "allows to air dry for at least 3 mintued [sic]" came from regarding the Skills Checklist Glucometer Machine information.</p> <p>At 10:04 a.m., on 9/16/15, the DHS indicated the facility was unable to determine when the last inservice was done for disinfection of the glucometer and the information for the Skills Checklist Glucometer Machine was</p>			

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F 9999 Bldg. 00	<p>provided from the Corporation.</p> <p>A policy titled, Glucometer Cleaning Guideline, no date, was received from the DHS on 9/16/15 at 10:57 a.m. The policy indicated, "...The following recommendations provide the guidance for cleaning and decontamination of glucometers that may be contaminated with blood and body fluids. Recommendations: 1. If glucometers are used from one resident to another they should be cleaned and disinfected after each use....3. After cleaning visible blood or body fluids or if no visible organic material is present, disinfect after each use the exterior surfaces following the manufacturer's directions...."</p> <p>3.1-18(a)</p>	F 9999	<p>1. Inservice training for identified employees listed have been completed. 2. All residents have potential to be affected by this practice. Facility will ensure that staff members will complete annual/mandatory training to include but not limited to abuse. Facility to complete in-servicing by October 17, 2015. 3. Facility to ensure that in-services are update and monitored regularly</p>	10/17/2015
	<p>3.1-14 Personnel</p> <p>(k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following:</p> <p>(1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention.</p>			

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	<p>(5) Needs of specialized populations served.</p> <p>(6) Care of cognitively impaired residents.</p> <p>(l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel.</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personal assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure staff received annual in-service education on residents</p>		<p>by the In-service Director. In-service director to monitor weekly for employees out of compliance. 4. In-service Director/Designee will monitor twice monthly X 3 months, and then monthly throughout next review. Findings to be reported to Executive Director/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>	

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	<p>rights and dementia for 4 of 11 staff members reviewed for residents' rights and dementia in-service education.</p> <p>Findings include:</p> <p>The Employee Records form and 11 employee personnel files were reviewed on 9/16/15 at 2:00 p.m. The Employee Records form indicated the following start dates: CNA #3-7/10/13, CNA #4-4/20/05, &amp; CNA #7-11/19/13.</p> <p>The employee personnel file for CNA #3 indicated the last annual training for resident's rights was 7/10/13 and the last annual training for dementia was 7/11/13.</p> <p>The employee personnel files for CNA #4 indicated the last annual training for dementia was 7/11/13 and CNA #7's last annual training for dementia was 11/20/13.</p> <p>During an interview with the Director of Health Services (DHS), on 9/17/15 at 10:29 a.m., the DHS indicated the above employees have not had annual dementia training since the dates listed above.</p> <p>The Time and Attendance-Employee Punch Histories provided by the DHS, on 9/17/15 at 11:00 a.m., indicated the following number of worked days since</p>			

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R 0000  Bldg. 00	<p>June 2015: CNA #3=14 days, CNA #4=3 days, and CNA #7=41 days.</p> <p>A policy titled, Summary of Educational Requirements for States Served by [name of corporation] Health Services, no date, was received from the DHS, on 9/17/15 at 12:29 p.m. The policy indicated, "...All nursing home staff with regular resident contact must receive six hours of dementia-specific training within six months of hire. Three hours of dementia-specific training is required annually thereafter...."</p> <p>The DHS indicated, 9/17/15 at 1:21 p.m., the facility was unable to locate a policy that indicated employees needed annual training for Resident's Rights, but the expectation was that employees complete annual training for Resident's Rights. The DHS further indicated the facility was unable to locate any other annual in-service training for Resident's Rights than what was listed above for CNA #3 and LPN #6.</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Facility number: 0004268</p>	R 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	

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R 0120 Bldg. 00	<p>Provider number: 155735 AIM number: n/a</p> <p>Census bed type: Residential: 30 Total: 30</p> <p>Sample: 10</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the</p>		statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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	<p>current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following:</p> <p>(A) The time, date, and location.</p> <p>(B) The name of the instructor.</p> <p>(C) The title of the instructor.</p> <p>(D) The names of the participants.</p> <p>(E) The program content of inservice.</p> <p>The employee will acknowledge attendance by written signature.</p> <p>Based on interview and record review, the facility failed to ensure staff received annual in-service education on abuse, residents rights and dementia for 4 of 11 staff members reviewed for annual in-service education.</p> <p>Findings include:</p> <p>The Employee Records form and 11 employee personnel files were reviewed on 9/16/15 at 2:00 p.m. The Employee Records form indicated the following start dates: CNA #3-7/10/13, CNA #4-4/20/05, LPN #6-4/18/12, &amp; CNA #7-11/19/13.</p> <p>The employee personnel file for CNA #3 indicated the last annual training for resident's rights was 7/10/13 and the last annual training for dementia was 7/11/13. The employee personnel file for CNA #3 also included verification of last training for abuse on 7/10/13.</p>	R 0120	<p>1. Inservice training for identified employees listed have been completed. 2. All residents have potential to be affected by this practice. Facility will ensure that staff members will complete annual/mandatory training to include but not limited to abuse. Facility to complete in-servicing by October 17, 2015. 3. Facility to ensure that in-services are update and monitored regularly by the In-service Director. In-service director to monitor weekly for employees out of compliance. 4. In-service Director/Designee will monitor twice monthly X 3 months, and then monthly throughout next review. Findings to be reported to Executive Director/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>	10/17/2015

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	<p>The employee personnel file for LPN #6 indicated the last annual training for resident's rights was 4/18/12 and the last annual training for dementia was 4/19/12</p> <p>The employee personnel files for CNA #4 indicated the last annual training for dementia was 7/11/13 and CNA #7's last annual training for dementia was 11/20/13.</p> <p>During an interview with the Director of Health Services (DHS), on 9/17/15 at 10:29 a.m., the DHS indicated the above employees have not had annual dementia training since the dates listed above.</p> <p>During an interview with the Business Office Manager, on 9/17/15 at 11:24 a.m., she indicated abuse training was to be completed annually.</p> <p>A document, no title/no date, was provided by the Assistant Director of Health Services, on 9/17/15 at 1:06 p.m. The document indicated the following number of days employees worked since June 1, 2015: CNA #3-14 days, CNA #4-74 days, LPN #6-39 days, CNA #7-30 days.</p> <p>On 9/17/15, at 1:30 p.m., the DHS indicated the facility was unable to locate verification for on-going/annual abuse</p>			

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	<p>training for CNA #3, since the training listed above.</p> <p>A policy titled, Abuse and Neglect Procedural Guidelines, dated 9/16/11, was received from the Administrator on 9/9/15 at 2:00 p.m. The policy indicated, "...b. Training i. Provide training for new employees through orientation and with ongoing training programs....ii. Documentation of training of [name of company] employees will be maintained with in-sevice records in the campus...."</p> <p>A policy titled, Summary of Educational Requirements for States Served by [name of corporation] Health Services, no date, was received from the DHS, on 9/17/15 at 12:29 p.m. The policy indicated, "...All nursing home staff with regular resident contact must receive six hours of dementia-specific training within six months of hire. Three hours of dementia-specific training is required annually thereafter...."</p> <p>The DHS indicated, 9/17/15 at 1:21 p.m., the facility was unable to locate a policy that indicated employees needed annual training for Resident's Rights, but the expectation was that employees complete annual training for Resident's Rights. The DHS further indicated the facility was unable to locate any other annual</p>			

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R 0217  Bldg. 00	<p>inservice training for the employees listed above.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to ensure a Resident/POA/Responsible Party signed a Service Plan. This affected 4 of 5 residents reviewed for clinical records.</p>	R 0217	<p>1. The Service Plan for the identified residents were mailed to residents family members for review and signature in situations where residents were unable to sign for themselves and families would not attend meetings. 2. All</p>	10/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155735	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/17/2015
NAME OF PROVIDER OR SUPPLIER  ASHFORD PLACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 N RILEY HWY SHELBYVILLE, IN 46176		
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	<p>1. The clinical Record for Resident #13 was reviewed on 9/17/15 at 11:00 a.m. The 8/7/15 service plan for Resident #13 was not signed by Resident #13, a family member, or a POA (power of attorney).</p> <p>2. The clinical Record for Resident #25 was reviewed on 9/17/15 at 11:00 a.m. The 8/7/15 service plan for Resident #25 was not signed by Resident #25, a family member, or a POA (power of attorney).3. The clinical record for Resident #4 was reviewed on 9/17/15 at 11:15 a.m. The diagnoses for Resident #4 included, but were not limited to, dementia and hiatal hernia according to the Diagnosis List, dated 3/13/15.</p> <p>An Assisted Living/Legacy/Legacy Lane Evaluation and Service Plan, dated 3/25/15, did not indicate a signature by the Resident and/or POA/Responsible Party.</p> <p>A Soc. Ser (Social Services) Careplan Progress Note, dated 4/22/15, indicated, "Res [Resident] Careplan meeting held today. Res., res family, and hospice were invited and hospice attended....Nursing: Service Plan reviewed...."</p> <p>4. The clinical record for Resident #18 was reviewed on 9/17/15 at 10:25 a.m.</p>		<p>residents living in residential living have potential to be affected by this practice. 3. Service Plans will be signed by residents and/or mailed to family members if they choose not to attend meetings to provide verification of levels of services provided requesting return receipt. 4. In-service Director/Designee will monitor twice monthly X 3 months, and then monthly throughout next review. Findings to be reported to Executive Director/Designee. Findings will also be brought forth to QAA for review by the IDT Team members and Medical Director on a monthly basis through next review or until deemed unnecessary by IDT Team Members and/or Medical Director. 5. Facility to be in compliance by date of certain: 10/17/2015.</p>		

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	<p>The diagnoses for Resident #18 included, but were not limited to, atrial fibrillation, hypertension and acute renal failure, according to the Diagnosis List, no date.</p> <p>An Assisted Living/Legacy/Legacy Lane Evaluation and Service Plans, dated 8/6/15, 5/18/15, &amp; 2/3/15, did not indicate a signature by the Resident and/or POA/Responsible Party.</p> <p>A Soc. Ser (Social Service) Careplan Progress Note, dated 3/18/15, indicated, "Res (Resident) careplan meeting held today. Res &amp; res family were invited but did not attend....Nursing: Service plan reviewed...."</p> <p>During an interview with the Social Services Director (SSD), on 9/17/15 at 12:02 p.m., the SSD indicated Service Plans were signed when Residents and/or POA/Responsible Parties attended a Careplan Conference. The SSD further indicated she was not aware of a process to have Service Plans signed, if the Resident and/or POA/Responsible Party did not attend the Careplan Conference.</p> <p>On 9/17/15, at 12:21 p.m., the Director of Health Services and the Assistant Director of Health Services indicated the facility did not have process in place to have a Resident and/or POA/Responsible</p>			

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	<p>Party sign a Service Plan, if they did not attend a Careplan Conference.</p> <p>A policy titled, "Guidelines for Evaluation and Service Plan, dated 10/2012, was received from the SSD, on 9/17/15 at 2:14 p.m. The policy indicated, "Purpose: To provide documentation of a nursing evaluation of functioning and care needs and develop a plan of care in response to identified results...4. The resident and/or responsible party should also review and sign the form...."</p>				