

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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F0000	<p>This survey was for the Investigation of Complaints IN0011712, IN118927, IN119258, IN122020, IN121937, IN122601 and IN123028.</p> <p>Complaint IN011712 - Substantiated. No deficiencies to the allegations are cited.</p> <p>Complaint IN118927 - Substantiated. No deficiencies to the allegations are cited.</p> <p>Complaint IN119258 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F315, and F323.</p> <p>Complaint IN122020 - Substantiated. Federal/state deficiencies related to the allegations are cited at F250.</p> <p>Complaint IN121937 - Substantiated. No deficiencies to the allegations are cited.</p> <p>Complaint IN122601 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN123028 - Substantiated. No deficiencies to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: January 14-18 & 22-23, 2013</p>	F0000		

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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	<p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Survey team: Honey Kuhn, RN, TC (January 14, 15, 16, 18, 22, 23, 2013) Julie Wagoner, RN (January 16, 17, 18, 2013)</p> <p>Census bed type: SNF/NF: 117 Total: 117</p> <p>Census payor type: Medicare: 13 Medicaid: 81 Other: 23 Total: 117</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on January 31, 2013, by Brenda Meredith, R.N.</p>				

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F0250 SS=E	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>1. Based on record review and interview, the facility failed to address a family concerns in regards to missing dentures and glasses for 1 of 1 resident reviewed for missing items in a sample of 9. (Resident "D")</p> <p>2. Based on record review and interview, the facility failed ensure Social Services facilitated Care Plan Meetings between staff, residents and family as evidenced for 3 of 3 residents reviewed for social services in a sample of 9. (Resident "D", Resident "F", and Resident "I")</p> <p>Finding include:</p> <p>1. The record of Resident "D" was reviewed on 01/18/13 at 8:30 a.m. Resident "D" was admitted to the facility on 12/31/10 with diagnoses including, but not limited to, dementia with behaviors, PVD (Peripheral Vascular Disease: impaired circulation) and non-inflammatory colitis.</p> <p>Review of Progress Notes indicated:</p>	F0250	<p>Preparation, submission, and implementation of this plan of correction does not constitutes an admission of or agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p><i>F 250</i> <i>It is the practice of this facility to provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</i></p> <p><u>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u> <i>Administrator met with POA for resident "D" on 12.31.12 and together determined the best strategy</i></p>	02/18/2013			

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	<p>"10/18/12 23:23 [11:23 p.m.] POA [Power of Attorney] reported missing dentures. Unable to allocate (sic) the dentures. Social services notified...."</p> <p>"10/19/12 12:31 [12:31 p.m.] Room searched for lower denture, unable to find, informed social services of missing denture...."</p> <p>"12/31/12 23:38 [11:38 p.m.] Res's [resident's] son came to this nurse at 1700 [5:00 p.m.] asking 'where is my mom's dentures and glasses?' This writer told res's son that staff looked every where [sic] but could not find [sic] res's dentures and glasses. Res's dentures and glasses have been missing for some days. Res takes her dentures out and puts them in the trash at times. Social services and Unit manager aware."</p> <p>The record did not contain any additional information in regards to the dentures and glasses of Resident "D." The record did not contain any social service notes or Care Plan Meeting notes related to the resident's issues.</p> <p>The SSD (Social Service Designee), DOH (Date of Hire) 09/13/10, was interviewed on 01/22/13 at 2:00 p.m. The SSD was queried if the glasses</p>		<p><i>to resolve his concerns. The following steps were taken for resident D: facility replaced dentures and glasses, Registered Speech Therapist collaborated with Registered Dietitian to maximize resident's dining experience and safety while preventing the loss of her dentures, additional strategies were put in place during meals, and a monitoring reminders were added to the nurses' medication administration record at meal time, resident's care plan and care guide were updated as well to reflect above needs. Resident's family was offered weekly care conferences with IDT for a minimum of 30 days and will be scheduled in accordance with MDS schedule thereafter and at family's request. IDT will review and document customer satisfaction during the care plan meeting utilizing the Care Conference Form.</i></p> <p><i>The families of resident D, F and I were invited to a care conference. The family of resident F attended a comprehensive care plan review on 1.20.13 (during the course of the survey). The family of resident "I" has been invited and scheduled for</i></p>		

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	<p>and denture issues were addressed at CPM's (Care Plan Meetings) with family and indicated they were not. The SSD did not provide information any CPM's were held with the family and or resident. The SSD indicated there was documentation and follow-up in regards to the missing dentures and glasses of Resident "D." Review of the documentation, provided by the SSD at the time, indicated:</p> <p>"Grievance Form...10/03/12, Grievance heard by (SSD name)/nursing....Statement of Concern: States resident dentures are missing. Action Plan: Thorough room search, laundry search in case resident took them out during meals and/or while in bed...Employee assigned: (SSD name)...Nature of resolution: SSD and ED explained to son that dentures have been replaced 2X [twice]within last year, both of which were paid for by facility....Due to staff 0 (not) being the cause of the dentures being lost, facility will not accept liability again to replace...[SSD signature] 10/03/12."</p> <p>"Grievance Form...10/18/12, Grievance heard by: nursing...Statement of Concern: Son reports dentures are missing. Action</p>		<p>2.13.13. <i>The family of resident D has a conference scheduled for 2.14.13.</i></p> <p><u>II. 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;</u></p> <ul style="list-style-type: none"> · <i>The care conference forms of all residents have been reviewed to identify other residents potentially in need of care plan conferences.</i> · <i>A monthly schedule for care plan meetings has been established and invitations to the care conference will be extended to the resident, the resident's family, or the resident's legal representative.</i> <p><u>III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</u></p> <ul style="list-style-type: none"> · <i>The Director of Nursing (DNS) provided education to the IDT related to the care planning policy of the facility.</i> · <i>A process improvement tool</i> 				

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	<p>Plan: room/laundry search, refer to ST [Speech Therapy] for possible difficulties c [with] chewing/swallowing...Employee assigned: [SSD's name]...Nature of resolution: Residents dentures were just [underlined] replaced on 10/05/2. Again informed the son that the facility cannot be liable d/t [due/to] resident removing dentures herself.... [SSD signature] 10/22/12."</p> <p>The SSD had no further documentation in regards to the losses, but did provide copies of 2 "Resident Personal Property Claim(s)" which indicated denture replacement on 12/27/11 and 02/26/12. The SSD did not provide claim information in regards to the denture loss on 10/03/12 and 10/18/12.</p> <p>The Administrator, DOH 11/18/12, was interviewed on 01/18/13 at 9:40 a.m. The Administrator indicated the staff began to monitor the residents dentures on the MAR (Medication Administration Record) in 01/2012.</p> <p>2A. The record of Resident "D" was reviewed on 01/18/13 at 8:30 a.m. Resident "D" was admitted to the facility on 12/31/10 with diagnoses including, but not limited to, dementia</p>		<p><i>has been developed to ensure ongoing compliance of care planning process; specifically related to participation of the resident, resident's family, or the resident's legal representative, the interdisciplinary team, and timely revisions.</i></p> <p><u>IV. 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;</u></p> <ul style="list-style-type: none"> ·Information gathered from the audits will be forwarded to the QAPI Committee for review x6 months. ·Trends or patterns noted will have Process Improvement Plans written and interventions implemented. ·QAPI committee to review and make recommendations for continued auditing or revision of Process Improvement Plan. ·The Executive Director and DNS will oversee this process. <p><u>By what date the systemic changes will be completed;</u></p> <ul style="list-style-type: none"> ·Feb. 18, 2013 		

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	<p>with behaviors, PVD (Peripheral Vascular Disease: impaired circulation) and non-inflammatory colitis.</p> <p>The record, reviewed for Social Service (SS) notes from 01/2011 to present, did not contain any documentation in regards to Care Plan Meetings (CPM's). The SS notes included 11 entries related to assessments for MDS (Minimum Data Set: a tool to assist in developing resident care plans), a 08/17/11 entry in regards to the resident needing new shoes, a 02/03/12 entry in regards to a medication change and a 03/06/12 entry in regard to an exit seeking episode.</p> <p>2B. The record of Resident "F" was reviewed on 01/18/13 at 10:00 a.m. Resident "F" was admitted to the facility on 02/21/04 with diagnoses including but not limited to, dementia, diabetes, incontinence, anxiety, and COPD (Chronic Obstructive Pulmonary Disease).</p> <p>Review of Social Service notes indicated no evidence of quarterly care plan meetings between the staff , resident and family.</p> <p>2C. The record of Resident "I" was</p>			

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	<p>reviewed on 01/22/13 at 10:30 a.m. Resident "I" was admitted to the facility on 02/04/10 with diagnoses including, but not limited to, hypertension, depression, PVD (Peripheral Vascular Disease: impaired circulation), pain, atrial fibrillation, incontinence, diverticulitis, and anemia.</p> <p>Review of Social Service notes indicated no evidence of quarterly care plan meetings between staff, resident, and family.</p> <p>The Administrator was interviewed on 01/18/13 at 9:30 a.m. The Administrator indicated the SSD (Social Service Designee) was responsible for coordination and implementation of quarterly Care Plan meetings</p> <p>The SSD (Social Service Designee), DOH (Date of Hire) 09/13/10, was interviewed on 01/22/13 at 2:00 p.m. The SSD was queried in regard to quarterly Care Plan Meetings. The SSD indicated some resident's CPM's were addressed in the Progress Notes and others on a paper form. The SSD indicated she mailed letters to residents families to inform them of scheduled CPM's and provided an undated list of residents for</p>			

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	<p>September. The list noted 10-12 resident names for the dates September 11, 13, 18, and 20. There was no indication if the dates referred to letters mailed or CPM's held. The SSD indicated there was no documentation in regard to notifications, rescheduling or actual CPM's for residents and/or family members on an ongoing basis. The SSD indicated there was no documentation regarding quarterly CPM's for residents "D", "F" and "I".</p> <p>Review of an undated Policy and Procedure, provided by the DNS (Director Nursing Services) on 01/18/13 at 11:00 a.m., did not address quarterly Care Plan Meetings in regards to coordination and notification of the entities involved.</p> <p>Review of a Job Description, "Social Services Specialist: 02/09/04," provided by the Administrator on 01/22/13 at 3:30 p.m., indicated:</p> <p>"GENERAL PURPOSE: Assist the Social Services Director/Coordinator in identifying and providing for each resident's social, emotional and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the</p>						

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	<p>planning for his/her discharge.</p> <p>ESSENTIAL JOB FUNCTIONS: SOCIAL SERVICES Duties: Develop a comprehensive social history assessment,...and complete the MDS and Care Plan for new admits....Document progress notes that relate to each resident's care plan when necessary and within policy timeframe." The job description was signed by the current SSD on 09/10/10.</p> <p>This Federal tag relates to Complaint IN00122020.</p> <p>3.1-34(a)</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure the care plans were followed for fall interventions for 1 of 3 residents reviewed for falls in a sample of 9. (Resident C) In addition, the facility failed to ensure the physician's orders were followed for 1 of 1 residents reviewed for physician's orders in a sample of 9. (Resident C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 01/16/13 at 1:30 P.M. Resident C was admitted to the facility on 01/17/12 with diagnoses, including but not limited to, history of neoplasm of the lung, chronic obstructive pulmonary disease, history of a deep vein thrombosis, and ischemic heart disease.</p> <p>The most recent Minimum Data Set (MDS) assessment for Resident C, completed on 11/29/12, indicated the resident was nonambulatory, required extensive staff assistance for</p>	F0282	<p>F282</p> <p><i>It is the practice of this facility that services be provided by qualified persons in accordance with the resident's written plan of care.</i></p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</u></p> <ul style="list-style-type: none"> ·Resident "C" has been assessed and the Care Plan has been updated to reflect physician orders specific to the resident's needs. ·The CNA assignment sheet has been updated to include Resident "C" interventions and equipment needs according to physician orders. <p><u>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;</u></p>	02/18/2013			

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	<p>transfer needs, dressing needs, and toileting needs.</p> <p>The current health care plans for Resident C indicated a plan, initiated on 10/17/12, regarding the resident risk for falls. The plan included interventions for the bed to be in the low position, call light or personal items available an din easy reach, footwear to prevent slipping, therapy referral, transfer assistance, transfer pole at bedside, wheelchair available, and gait belt.</p> <p>On 01/17/13 from 9:10 A.M. - 4:00 P.M., Resident C was observed to spend his time in his room seated in a wheelchair. At 4:00 P.M. on 01/17/13, CNA #16 instructed and minimally assisted the resident to stand and hang onto the transfer pole at his bedside while she changed the resident's brief and provided minimal personal hygiene. The CNA did not use a gait belt during the procedure.</p> <p>Interview on 01/17/13 at 2:30 P.M., prior to the observation, with CNA #16 indicated she was new and had only worked at the facility a few months. She indicated she had an assignment worksheet for the residents she was responsible for in her pocket. Observation of the assignment sheet</p>		<p><i>·Residents with falls since 01/01/13 have been reviewed and had their care plans and CNA assignment sheets updated.</i></p> <p><u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u></p> <p><i>·CNA's #15 & 16 have had re-education for gait belt use, transfers, incontinent care, and the use of CNA Assignment sheets.</i></p> <p><i>·Licensed nurses will be re-educated on following physician orders and updating care Plans and CNA Assignment Sheets.</i></p> <p><i>·CNA's will be re-educated on transfer training and the use of gait belts, and following the CNA assignment sheet.</i></p> <p><i>·New Physician orders are reviewed by the IDT in AM Clinical Start up Monday through Friday and care plans and CNA assignments sheets will be updated as needed at that time.</i></p> <p><u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</u></p>				

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	<p>indicated she was to provide the care for Resident C. The assignment sheet for Resident C indicated he was "incontinent, " used a "Sara lift", a wheelchair, and had chair alarms. There was no indication of the assignment form to utilize a gait belt. CNA #16 indicated the resident usually stood for her and had a transfer pole in his room. She indicated she did not utilize a Sara Lift (standing lift) for Resident C, did not utilize a gait belt for Resident C, and did not think he had a chair alarm on his wheelchair. She indicated she at times had observed Resident C wheeling himself out of the bathroom and thought perhaps he toileted himself at times but she was not sure about the issue.</p> <p>Interview with CNA #15, on 01/17/13 at 2:05 P.M., indicated she sometimes took care of Resident C on the day shift. She indicated although the assignment sheet had a "Sara lift" for Resident C he actually transferred with a transfer pole and one assist in his room. She indicated he also tried to toilet himself at times. She indicated there was no chair alarm and no special instructions to utilize any type of equipment while transferring the resident.</p>		<p><u>assurance program will be put into place;</u></p> <ul style="list-style-type: none"> ·Information gathered from the audits will be forwarded to the QAPI Committee for review x6 months. ·Trends or patterns noted will have Process Improvement Plans written and interventions implemented. ·QAPI committee to review and make recommendations for continued auditing or revision of Process Improvement Plan. ·The Executive Director and DNS will oversee this process. <p><u>By what date the systemic changes will be completed;</u></p> <ul style="list-style-type: none"> ·Feb. 18, 2013 		

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	<p>Nursing progress notes, dated 11/02/12 at 10:10 A.M., indicated the CNA had informed the nurse she had to lower the resident to the floor during a transfer because the resident had become "unstable" when she (the CNA) was transferring the resident from the bed into the wheelchair.</p> <p>Review of the interdisciplinary fall review investigation, completed on 11/02/12, indicated the recommendation was for a gait belt and non-skid footwear to be utilized when transferring Resident C.</p> <p>Interview with the Administrator and the Director of Nursing, on 01/18/13 at 12:00 P.M., indicated the facility had "a lot" of new staff. There was no indication how the new staff were supposed to know the fall interventions to be utilized if the interventions on the assignment sheets were not being followed and/or were not of the form.</p> <p>2. Resident C was observed on 01/16/13 and on 01/17/13 in the mornings from 9:00 A.M. - 12:00 P.M. and in the afternoons from 1:00 P.M. - 3:00 P.M., seated in his wheelchair in his room. The resident was noted to have white tube type socks and was wearing and/or resting his</p>			

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	<p>stocking feet on top of rubber soled slippers.</p> <p>The clinical record for Resident C was reviewed on 01/16/13 at 1:30 P.M. Resident C was admitted to the facility on 01/17/12 with diagnoses, including but not limited to, history of neoplasm of the lung, chronic obstructive pulmonary disease, history of a deep vein thrombosis, and ischemic heart disease.</p> <p>Nursing progress notes, dated 10/08/12, indicated the resident had been sent to the emergency room and returned to the facility with a diagnosis of cellulitus of his lower legs.</p> <p>The current physician's order for Resident C included an order, dated 10/25/12, for TED (antiembolism stockings), to be worn in during the day and removed at bedtime. A December 2012 treatment record for Resident C indicated nursing staff had documented the TED hose as being worn through 12/11/12 and the rest of the month was left blank. On 01/18/13 at 10:00 A.M., Resident C was observed seated in his room in his wheelchair. The resident was noted to be wearing the TED hose stockings and black dress shoes.</p>				

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	<p>Interview with Resident C indicated he knew he was supposed to be wearing the TED hose but he indicated he usually did not wear the stockings.</p> <p>This Federal tag relates to Complaint IN 119258.</p> <p>3.1-35(g)(2)</p>			

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record reviews and interviews, the facility failed to ensure bladder continency was thoroughly assessed and an individualized toileting plan implemented to ensure 1 of 3 residents reviewed for incontinence in a sample of 9 had as much bladder continency restored as was possible. (Residents C and K)</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 01/16/13 at 1:30 P.M. Resident C was admitted to the facility, on 01/17/12, with diagnoses, including but not limited to, history of neoplasm of the lung, chronic obstructive pulmonary disease, history of a deep vein thrombosis, and ischemic heart disease.</p>	F0315	<p>F315</p> <p><i>It is the practice of this facility to ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</i></p> <p><u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</u></p> <p>· Resident "C" Bowel and Bladder Evaluation Tool was completed and a care</p>	02/18/2013			

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	<p>The most recent Minimum Data Set (MDS) assessment for Resident C, completed on 11/29/12, indicated the resident was nonambulatory, required extensive staff assistance for transfer needs, dressing needs, and toileting needs, and was frequently incontinent of his bladder.</p> <p>The current health care plans for Resident C, current through 01/14/13, indicated there was no specific plan related to the resident's bladder incontinence needs. A care plan to address Resident C's physical functioning deficits included an intervention to provide toileting assistance. There was no specific instructions regarding the toileting assistance required by Resident C.</p> <p>The current bladder incontinence assessment, dated 09/10/12, as a quarterly review, indicated the Resident C had a history of a CVA/stroke, and diabetes, and no urinalysis or physical examination had been performed as part of the bladder assessment. Sections 1, 2, 4, 6, 7, and 8 of the assessment form were not completed. There was also no individual bladder patterning documentation available on the clinical record.</p>		<p>plan completed to address Resident "C" elimination needs.</p> <p><u>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.</u></p> <ul style="list-style-type: none"> · Residents who have been admitted since 01/01/13 have had the Bowel and Bladder Evaluation Tool completed as per protocol. · Residents who are admitted or re-admitted into the facility will have a Bowel and Bladder Evaluation Tool completed within 72 hours of admitting into facility. Also this tool will be completed annually or with any significant change. The resident will then be care planned for the appropriate toileting program according to the results of the evaluation tool. · Resident who do not have an evaluation tool in place will have the Bowel and Bladder Evaluation Tool completed with their next upcoming MDS assessment (quarterly, change of condition or annual). · New Residents will have an evaluation completed with each admission, re-admission 		

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	<p>Interview with CNA #16 and 17, who were assigned to provide care for Resident C, on 01/17/13 on the first and second shifts, indicated the resident was "toileted" every two hours because "incontinence" was indicated on the CNA assignment form. However, CNA #17 indicated the bathroom was too crowded and she did not actually provided toileting assistance for Resident C. She indicated she just changed his brief.</p> <p>Interview with Resident C, who was documented as having intact cognitive status, on 01/17/13 at 4:10 P.M., indicated he was very seldom given an opportunity to actually sit on the toilet to urinate or defecate.</p> <p>On 01/17/13 from 9:10 A.M. - 11:45 A.M., Resident C was observed seated in his room in his wheelchair. There were dry food crumbs noted to be on the resident's sweatshirt and sweatpants in his lap area. At 11:45 A.M., the resident's meal tray was brought to his room and placed in front of him on an overbed table.</p> <p>On 01/17/13 at 1:00 P.M., Resident C was observed to still be seated in his room in his wheelchair with a partially consumed lunch tray on the overbed table in front of him. He remained in</p>		<p>and annual or change of condition assessment following their next upcoming assessment) <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</u></p> <ul style="list-style-type: none"> · Licensed nursing staff will be re-educated on completion of the Bowel and Bladder Tool which includes a 3 Day Bowel and Bladder Record if indicated. · CNA's will be re-educated on facility toileting programs and the use of CNA assignment sheets, and Incontinent Care according to the resident's plan of care. · CNA's #16 and 17 have been re-educated the use of CNA assignment Sheets and Incontinent Care. · New admits, readmits will be reviewed in the AM Clinical meeting to ensure that Bowel and Bladder evaluations have been implemented. A tracking tool will be developed to ensure completion of the Bowel and Bladder Evaluation/3 Day Record. · Unit Mangers/Designee will conduct audits of new admission/re-admissions, 				

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	<p>his wheelchair with the dry food crumbs on his outfit from 1:00 P.M. - 4:00 P.M., when CNA #17 had Resident C stand at the bedside hanging onto a transfer pole while she changed the resident's brief and provided personal hygiene. At the time when the resident was changed, at 4:00 P.M., there were deep indentation's on his skin from the brief around his waist line. The resident's brief was saturated with urine. Thus the resident was not toileted and/or checked for incontinence from 9:00 A.M. - 4:00 P.M., for at least 7 hours.</p> <p>Interview, on 01/17/13 at 2:00 P.M. and 2:30 P.M., with both CNA #16 and #17 indicated at times Resident C would request to be changed and/or toileted and at times Resident C would attempt to toilet himself.</p> <p>This Federal tag relates to Complaint #IN00119258.</p> <p>3.1-41(a)(2)</p>		<p>Significant changes, quarterly and annual evaluations weekly x 6 weeks to validate that assessments have been completed and interventions implemented per facility protocol.</p> <ul style="list-style-type: none"> · Unit Managers/Designee will conduct observation audits of incontinent residents on all shifts 5 x week for 4 weeks, then 3 x a week x 8 weeks, then weekly x 3 months until 30 days of compliance is met. <p><u>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.</u></p> <ul style="list-style-type: none"> · Information gathered from the audits will be forwarded to the QAPI Committee x 6 months. · Trends or patterns noted will have Process Improvement Plans written and interventions implemented. · QAPI committee to review and make recommendations for continued auditing or revision of Process Improvement Plan. · The Executive Director and DNS will oversee this process.. 				

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			<u>By what date the systemic changes will be completed.</u> Feb 18, 2013	

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F0323 SS=G	<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, record review, and interviews, the facility failed to ensure interventions were implemented and adequate supervision was provided to prevent falls for 3 of 5 residents reviewed for falls in a sample of 9. (Resident "C", Resident "D", and Resident "F")</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 01/16/13 at 1:30 P.M. Resident C was admitted to the facility, on 01/17/12, with diagnoses, including but not limited to, history of neoplasm of the lung, chronic obstructive pulmonary disease, history of a deep vein thrombosis, and ishcemic heart disease.</p> <p>The most recent Minimum Data Set (MDS) assessment for Resident C, completed on 11/29/12, indicated the resident was was nonambulatory, required extensive staff assistance for transfer needs, dressing needs, and toileting needs.</p>	F0323	<p>F323 <i>It is the practice of this facility to 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.</i></p> <p><u>I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</u> ·Residents "C" "D" and "F" have been re-assessed and had their care plans and CNA assignment sheets updated to reflect each residents individualized needs.</p> <p><u>II. 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.</u> ·Residents identified at risk</p>	02/18/2013			

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	<p>The current health care plans for Resident C indicated a plan, initiated on 10/17/12, regarding the resident risk for falls. The plan included interventions for the bed to be in the low position, call light or personal items available an din easy reach, footwear to prevent slipping, therapy referral, transfer assistance, transfer pole at bedside, wheelchair available, and gait belt.</p> <p>On 01/17/13 from 9:10 A.M. - 4:00 P.M., Resident C was observed to spend his time in his room seated in a wheelchair. At 4:00 P.M. on 01/17/13, CNA #16 instructed and minimally assisted the resident to stand and hang onto the transfer pole at his bedside while she changed the resident's brief and provided minimal personal hygiene. The CNA did not use a gait belt during the procedure.</p> <p>Interview on 01/17/13 at 2:30 P.M., prior to the observation, with CNA #16 indicated she was new and had only worked at the facility a few months. She indicated she had an assignment worksheet for the residents she was responsible for in her pocket. Observation of the assignment sheet indicated she was to provide the care for Resident C. The assignment</p>		<p>for falls have been identified through chart review and have been re-assessed.</p> <ul style="list-style-type: none"> ·Residents identified at risk have had their care plans and CNA assignment sheets updated. ·Room observations, Care Plans, Physician Orders and CNA assignment sheets have been audited to ensure they are aligned with Residents needs. <p><u>III. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</u></p> <ul style="list-style-type: none"> ·New admits/re-admits will have a Fall Risk Assessment completed at the time of admission. Resident found to be "at risk" will be care planned as such and interventions put in place and reflected on the CNA assignment sheet. ·Licensed staff have been re-educated on the completion of the Fall Risk Assessment and Facility Fall Protocols. ·CNA's have been re-educated on Safe Transfers, the use of gait belts and following CNA assignment sheets. ·Fall investigations (DQI's) will 				

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	<p>sheet for Resident C indicated he was "incontinent, "used a "Sara lift [mechanical standing lift]", a wheelchair, and had chair alarms. There was no indication of the assignment form to utilize a gait belt. CNA #16 indicated the resident usually stood for her and had a transfer pole in his room. She indicated she did not utilize a Sara Lift for Resident C, did not utilize a gait belt for Resident C, and did not think he had a chair alarm on his wheelchair. She indicated she at times had observed Resident C wheeling himself out of the bathroom and thought perhaps he toileted himself at times but she was not sure about the issue.</p> <p>Interview with CNA #15, on 01/17/13 at 2:05 P.M., indicated she sometimes took care of Resident C on the day shift. She indicated although the assignment sheet had a "Sara lift" for Resident C he actually transferred with a transfer pole and one assist in his room. She indicated he also tried to toilet himself at times. She indicated there was no chair alarm and no special instructions to utilize any type of equipment while transferring the resident.</p> <p>Nursing progress notes, dated</p>		<p>be reviewed daily x 5 days a week during AM Clinical Start up and care plans and C.N.A. sheets will be updated.</p> <ul style="list-style-type: none"> ·Unit Mangers will complete audits weekly for 8 weeks to ensure fall interventions are updated on the care plans and C.N.A. sheets. ·Unit Managers/Designee will conduct observation audits on all shifts 5 x week for 4 weeks, then 3 x a week x 8 weeks, then weekly x 3 months. ·Staff will be Re-educated on Safety and facility protocols. <p><u>IV. 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.</u></p> <ul style="list-style-type: none"> ·Information gathered from the audits will be forwarded to the QAPI Committee for review. This is an ongoing process. ·Trends or patterns noted will have Process Improvement Plans and interventions implemented. ·QAPI committee to review and make recommendations for continued auditing or revision of Process Improvement Plan. ·The Executive Director and DNS will oversee this 				

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	<p>11/02/12 at 10:10 A.M., indicated the CNA had informed the nurse she had to lower the resident to the floor during a transfer because the resident had become "unstable" when she (the CNA) was transferring the resident from the bed into the wheelchair.</p> <p>Review of the interdisciplinary fall review investigation, completed on 11/02/12, indicated the recommendation was for a gait belt and non-skid footwear to be utilized when transferring Resident C.</p> <p>Interview with the Administrator and the Director of Nursing, on 01/18/13 at 12:00 P.M., indicated the facility had "a lot" of new staff. There was no indication how the new staff were supposed to know the fall interventions to be utilized if the interventions on the assignment sheets were not being followed and/or were not of the form.</p> <p>2. The record of Resident "D" was reviewed on 01/18/13 at 8:30 a.m. Resident "D" was admitted to the facility, on 12/31/10, with diagnoses including, but not limited to, dementia with behaviors, PVD (Peripheral Vascular Disease: impaired circulation) and non-inflammatory colitis.</p>		<p>process..</p> <p><u>By what date the systemic changes will be completed.</u> ·Feb 18, 2013</p>				

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	<p>Review of the record indicated Resident "D" had incurred a fall, on 09/07/12, when the resident was found seated on the floor next to the bed. Review of the most recent MDS (Minimum Data Set: a tool to assist in residents plan of care) indicated the resident required assist from bed to chair.</p> <p>Review of a care plan to address fall risk for resident "D" indicated, "01/08/13 Transfer assistance [up to two person if needed]."</p> <p>Review of the "CNA Assignment Sheet: 01/11/13", indicated the resident as "IND" for independent for transfers.</p> <p>Interview with the LPN-Unit Manger, on 01/14/13 at 10:00 a.m. during initial resident review, indicaed the CNA worksheets were accurate and up to date.</p> <p>3. The record of Resident "F" was reviewed on 01/18/13 at 10:00 a.m. Resident "F" was admitted to the facility, on 02/21/04, with diagnoses including but not limited to, dementia, diabetes, incontinence, anxiety, and COPD (Chronic Obstructive Pulmonary Disease).</p>						

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	<p>Review of the most recent MDS (Minimum Data Set: a tool to assist in residents plan of care), dated 11/19/12, indicated the resident was cognitive, and required assistance with transfers, eating, dressing and toileting.</p> <p>Review of the record indicated Resident "F" had incurred 8 falls between 11/02/12 and 01/12/13. Review of the fall investigations indicated:</p> <p>"11/02/12 14:45 (2:45 p.m.)... found laying in front of recliner...No injury." "11/04/12 18:30 (6:30 p.m.)...resident reported sliding from recliner to floor... No injury." "11/24/12 19:10 (7:10 p.m.)...found...leaning to the raised recliner...No injury." "12/08/12 12:30 (12:30 p.m.)...near recliner...2 cm laceration to right eye brow." "12/18/12 12:20 (12:20 p.m.)...fell in room...reaching for glasses...No injury." "12/31/12 20:00 (8:00 p.m.)...next to recliner...No injury." "01/12/13 04:20 (4:20 a.m.)...on floor by bedside...sitting position...No injury."</p> <p>Review of the "Provide Summary..."</p>						

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	<p>area of the fall investigations indicated various suggestions to family but no family input or involvement. A review of the Social Service notes indicated no documentation in regards to a care plan meeting in regards to the resident's frequent falls.</p> <p>The most recent fall resulted in injury. Review of the Fall Investigation included, but was not limited to:</p> <p>"01/12/12 18:15 (6:15 p.m.) DESCRIPTION OF EVENT: ...B wing dining room...skin tear right forehead, 0.7 cm [centimeters] X [by] 1.26 cm X 20.1 cm. @ hematomas (R) (right) forehead and right temple, 6 cm X 4.5 cm and 3 cm X 3 cm.</p> <p>RESIDENT INTERVIEW SUMMARY: Could not explain how she got on the floor.</p> <p>SPECIFY RECOMMENDATIONS/INTERVENTIONS TAKEN TO PREVENT REOCCURRENCE:...Therapy screen and personal alarm."</p> <p>PROVIDE SUMMARY AND OUTCOME OF INVESTIGATIVE FINDINGS: Resident c (with) multiple falls. Very poor safety</p>						

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	<p>awareness. Hx (history) of refusing therapy. Attempts to stand, ambulate s (without) assistance. Multiple interventions in place. Resident safety concern - Plavix & ASA (anticoagulants: blood thinners) use, large hematoma c fall. Neuro (neurology) checks WNL (within normal limits). Staff state family refused room change to bring closer to Nurses station. Transfer w/c (wheelchair) used"</p> <p>Review of care plans indicated the care plan addressing "Self care impairment" indicated: "01/16/13 Transfer assistance up to x2 extensive assist. Utilize mechanical lift as needed." "01/16/13 Toileting assistance at least every two hours and as needed." Review of the "At risk for falls..." care plan indicated initiation date of "12/06/12" and "Interventions:...RESOLVED: Transfer pole at bed side and in bathroom, and by recliner. Resolved 12/06/12."</p> <p>Review of the "CNA Assignment Sheet: 01/11/13", for Resident "F" indicated: "Toileting: cont/incont (continent/incontinent)" "Transfers: X1 assist/ind</p>			

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	<p>(independent) at times" "Mobility: AMB/WC (ambulatory/wheelchair)" "Safety: Fall risk. Transfer pole by bed, NSS walk way, call light @ recliner."</p> <p>Resident "F" was observed, on 01/17/13 at 8:30 a.m., for a transfer with 1 assist by CNA #5. CNA #5 did not use a transfer belt. Resident "F" was observed with mask like facial bruising in various stages of healing, and varying in color from purple to pinkish yellow.</p> <p>Review a Policy & Procedure, "Transfer Activities: 2006", provided by the DNS (Director Nurses Services) on 01/22/13 at 9:00 a.m., indicated: "...5. Apply transfer belt..."</p> <p>Resident "F" was observed throughout the survey with mask like facial bruising in various stages of healing, and varying in color from purple to pinkish yellow.</p> <p>The investigation of the 01/12/13, fall in the dining room did not indicate why the resident was in the dining room unattended or address how the facility would address the fall to</p>						

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	<p>prevent further occurrences.</p> <p>Review of the facility Policy and Procedure, "Verification of Investigation of Alleged Mistreatment, Abuse, Neglect, Injuries of Unknown Source and Mispronunciation of Resident Property Guideline: 01/2011", and provided by the Administrator on 01/14/13 at 11:00 a.m., indicated: "...Investigation...The investigation includes interviews of employees, visitors or residents who may have knowledge of the alleged incident. Only factual information is documented... Corrective action:...The center makes reasonable efforts to determine the cause of the alleged violation and takes corrective action consistent with the investigation findings and to eliminate any ongoing dangers to the resident...Appropriate steps are taken to prevent recurrence of the incident. This may include in-services or other measures as appropriate. The steps taken are documented...."</p> <p>This Federal tag refers to Complaint IN119258 and Complaint IN122601.</p> <p>3.1-45(a)(2)</p>						

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F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interviews, the facility failed to ensure the needs of a resident regarding hydration were met for 1 of 3 residents reviewed for hydration in a sample of 9. (Resident K)</p> <p>Finding includes:</p> <p>1. The clinical record for Resident K was reviewed on 01/17/13 at 1:30 P.M. Resident K had diagnoses, including but not limited to diabetes, congestive heart failure, dementia, hypertension, and cerebrovascular disease.</p> <p>A Comprehensive Metabolic Panel (blood lab test), ordered on 10/11/12 after a nurse practitioner had examined the resident, indicated the resident's BUN (Blood urea nitrogen level) was elevated to 93 mg/dL, and the resident's Creatinine level was elevated to 3.48 mg/dL, and the Potassium level was critically elevated to 6.3 mg/dL. On 10/12/12 at 17:51 (5:51 P.M.), an order was received to send the resident to the acute care facility.</p>			F0327	<p>F327 It is the practice of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p><u>I. The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows:</u> ·Resident "K" has been reviewed by the registered dietician and a care plan was implemented for dehydration.</p> <p><u>II. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows:</u> ·Residents' at risk have been identified through chart and physician order review and have had their care plans updated to reflect identified needs. ·Residents with fluid intake orders will have their fluid</p>		02/18/2013

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	<p>The acute care center's History and Physical assessment, completed on 10/12/12, indicated Resident K was "severely dehydrated with acute renal failure and hyperkalemia [elevated potassium]. He has a multitude of medical problems, many of which are stable, but he appears to have dried out at the nursing home..." The resident was rehydrated, treated for an urinary tract infection, and readmitted to the facility on 10/16/12 with orders, including but not limited to, "must drink 1200 cc (cubic centimeters) of fluid q [every] day."</p> <p>A quarterly nutritional review, dated 10/12/12, did not reflect the 10/11/12 blood test results. A 10/26/12, "general note" indicated the resident had lost weight, had recently returned from the hospital due to "not eating" and was readmitted with a diagnosis of "UTI" (urinary tract infection). The note indicated "nursing has reported fluids encouraged...." The noted indicated the following recommendations: "Continue with current nutritional interventions. Will continue to monitor via weekly weights x 2 weeks." The residents dehydration and fluid needs were not reassessed.</p>		<p><i>intake monitored per MD order.</i></p> <ul style="list-style-type: none"> ·The IDT team will review identified "at risk" and make recommendations to MD and RD for further interventions. <p><u>III. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows:</u></p> <ul style="list-style-type: none"> ·Nursing staff will be re-educated on signs and symptoms of dehydration and the necessary documentation per facility protocol and MD orders ·The DNS and RD will ensure that resident's at risk for dehydration will have a comprehensive care plan developed to include monitoring for signs and symptoms of dehydration. ·Residents identified to be at risk for dehydration will be reviewed daily as a portion of clinical meeting Monday through Friday for any changes in status to include potential signs and symptoms of dehydration. ·Residents with a physician order for fluid intake will be reviewed daily as a portion of clinical meeting Monday through Friday for any 		

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	<p>An additional general note, also dated 10/26/12, indicated a recommendation to discontinue the "Must drink 1200 cc q day," ordered by the physician on 10/18/12, and recommended monitoring the resident's hydration status by obtaining additional BMP (blood metabolic panel) tests.</p> <p>Review of the Treatment record for Resident K, for October 2012, indicated the "Must drink 1200 cc fluid q day" was on the form but three of the 9 shifts had documented a signature by the order, but there was no documentation of the amount of fluids the resident had actually consumed. The resident's meal consumption was documented . However, the resident's meal consumption was documented for the evening shift on 10/14/12, when the resident was still in the acute care facility.</p> <p>Review of the current health care plans for Resident K, revised on 12/19/12, indicated there was no specific plan to address the resident's risk of dehydration and/or actual dehydration needs.</p> <p>3.1-46(b)</p>		<p><i>changes in status to include potential signs and symptoms of dehydration and intake.</i></p> <ul style="list-style-type: none"> · <i>This will be an ongoing process per Policy.</i> <p><u>IV. 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:</u></p> <ul style="list-style-type: none"> · <i>The results of these audits will be presented to the QAPI committee x 3 months.</i> · <i>Trends or patterns noted will have Process Improvement Plans written and interventions implemented.</i> · <i>QAPI committee to review and make recommendations for continued auditing or revision of Process Improvement Plans</i> · <i>The Executive Director will oversee this process.</i> · <i>The DNS/Designee is responsible for compliance.</i> <p><u>By what date the systemic changes will be completed.</u></p> <ul style="list-style-type: none"> · <i>Feb 18, 2013</i> 				

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