

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/07/2015
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF BREMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506
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F 0000  Bldg. 00	<p>This visit was for the Recertification and State Licensure survey.</p> <p>Survey dates: September 30 to October 7, 2015.</p> <p>Facility Number: 000506 Provider Number: 155474 AIM Number: 100266530</p> <p>Census bed type: SNF/NF: 62 Total: 62</p> <p>Census payor type: Medicare: 03 Medicaid: 40 Other: 19 Total: 62</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 14454 on October 15, 2015.</p>	F 0000	<p>F 0000</p> <p>The facility requests that this plan of correction be considered its credible allegation of compliance for the survey conducted on October 7, 2015. 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 submitted timely and in accordance with State and Federal Regulatory Guidelines.</p>	

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

TITLE

(X6) DATE

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

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F 0242 SS=A Bldg. 00	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>Based on observation, record review and interviews, the facility failed to offer bathing choices for 1 of 20 residents interviewed regarding choices. (Resident #11)</p> <p>Finding includes:</p> <p>During an interview on 10/01/2015 at 01:11 P.M., Resident #11 indicated she only received showers as there was no choice given. She indicated at home she liked to take a bath sometimes.</p> <p>The clinical record for Resident #11 was reviewed on 10/05/2015 at 10:24 A.M. Resident #11 was admitted to the facility, on 10/27/14, with diagnoses, including but not limited to: hypertension and anxiety.</p>	F 0242	<p>It is the intent of our facility to allow all residents to make choices consistent with their interests, their care plans, and their rights. We respectfully request that this tag be reviewed because the initial social service history form that coincided with her plan of care upon admission, her choice was clearly marked and indicated her preference was a shower. Her annual assessment is due in Novemeber and it would have been reviewed with her again and updated with any changes at that time. 1. Resident #11 was interviewed regarding her bathing preferences. Her care plan and CNA care card were both updated. 2. All residents were interviewed by IDT using the Abaqis Resident Interview tool, Section B – Choices. Care plan and care guides were updated to reflect resident's current</p>	11/06/2015

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	<p>The annual MDS (Minimum Data Set) assessment, completed on 09/03/15, indicated the resident was moderately cognitively impaired as indicated by a score of 9 of 15 on the BIMS (Brief Interview for Mental Status). The assessment also indicated it was very important for her to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>The current care plans for Resident #11 did not include any plan to address the resident's choices or preferences with bathing needs.</p> <p>During an interview on 10/05/15 at 9:34 A.M., LPN (Licensed Practical Nurse) #51 indicated she had worked at the facility over ten years and although there was a working, jetted tub in the 300 hall "spa" room, she had never known any resident to take and/or be offered a tub bath. She did not know why the tub room was not utilized.</p> <p>A shower schedule for Resident #11, located on the South nurse's station, indicated the resident was to receive a shower on Wednesdays and Saturdays on the 2nd shift.</p> <p>During an interview on 10/05/2015 at 3:39 P.M., CNA (Certified Nursing Assistant) #50 indicated the tub bath was</p>		<p>status. 3. Social Services will be re-educated by SDC and/ or designee related to policy and procedure regarding resident choices as related to bathing. 4. PI (Process Improvement) tool has been developed to monitor compliance related to resident bathing choices by DON/designee and will be completed weekly x 4 and then monthly x 3 and then quarterly thereafter. Results will be reviewed at the monthly QAPI meeting until 100% compliance has been consistently achieved.</p>	

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	<p>never used so she doubted that anyone had every offered any resident a tub bath.</p> <p>During a second interview on 10/06/2015 at 9:40 A.M. Resident #11 indicated no one had ever told her or offered her a tub bath. She indicated she thought they did not have a tub. She was surprised to hear the facility had a tub. She asked if she wanted could she have a tub bath.</p> <p>During an interview on 10/07/2015 at 9:59 A.M., the SSD (Social Service Director) indicated the former Activity Director would have been responsible for care planning any specific resident preferences. She indicated since there was no current activity director, she would address the areas for Resident 11. The SSD also indicated in the past 8 months or so the tub had been repaired by the Maintenance Supervisor but other than it had previously been broken, she was not sure why residents were not being given a choice regarding bathing.</p> <p>3.1-3(u)(2)</p>			

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F 0248 SS=E Bldg. 00	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure activities were provided per the Activity Calendar and per individual care plans for 3 of 3 residents reviewed for activities (Resident #20, 28 and 16) in the sample of 40, and 3 of 3 residents in an expanded sample. (Residents #27,82, and 4)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #20 was reviewed on 10/05/2015 at 9:45 A.M. Resident #20 was admitted to the facility, on 04/01/14, with diagnoses, including but not limited to: cerebral vascular accident, diabetes, aphasia, convulsions, hypertension, dysphasia, esophageal reflux, constipation and contracture's at multiple joints.</p> <p>A quarterly activity note, completed on 08/05/15, indicated the resident received 1:1 visits 2 x (times) a week, and sensory group 3 x week to continue for social and</p>	F 0248	<p>It is the intention of this facility to ensure activities are designed, in accordance with the comprehensive assessments and the interests of the residents to meet their physical, mental and psychosocial well- being. 1. Activity assessments have been reviewed and updated, along with activity care plans for residents #20, #28, #16, #27, #82 and #4. 2. Activity assessments have been reviewed and updated with resident preferences and care plans have been reviewed and have been updated accordingly. 3. Activity Director and Activity Assistant have been re-educated by the CEO/ designee with regards to facility policy regarding activities. 4. PI tool has been developed to monitor compliance with activity calendar, participation and with 1:1 visits in accordance with resident plan of care and will be completed weekly by the CEO/designee x 4 and monthly x 3 and then quarterly thereafter. Results will be presented by Activity director/designee at the monthly QAPI meeting until 100% compliance has been consistently</p>	11/06/2015
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	<p>sensory stimulation. The note indicated the resident had been noted to have an increase in her response with more vocalizing and more tracking with her eyes. The note also indicated the resident's family and Hospice visited with her.</p> <p>A care plan related to psychosocial well-being, reviewed as current on 08/05/15, indicted activities were to be provided in group setting, independently, and 1:1 room visits. The activities were to accommodate resident loss such as cognitive, mobility, vision or hearing. Activities were to provide for ability to attend functions outside of room as tolerated and keep center for Hospice and family updated on condition and changes.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 08/12/15, indicated the resident was severely cognitively impaired, required total staff assistance for wheelchair locomotion, transfers, and ADL (Activity of Daily Living) assistance. The resident was always incontinent of her bowels and bladder. The resident was at risk for developing pressure ulcers but had no pressure ulcers.</p> <p>Resident #20 was observed to be lying in her darkened room, in her bed on</p>		achieved.	

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	<p>10/05/2015 from 8:45 A.M. to 11:53 A.M. At 11:53 A.M., she was transferred into a Broda reclining wheelchair and left in her room. There was no activities or any kind of stimulation provided for Resident #20 other than incontinence care, which was provided at 11:03 A.M.</p> <p>On 10/05/15 at 1:13 P.M., Resident #20 was observed to be in her Broda chair in the day lounge beside the television. The room was darkened, the blind were pulled, and the television was playing an old black and white movie. The resident was noted to remain in the day lounge by the television from 1:13 P.M. to 1:30 P.M. Other than the television, there was no other stimulation provided to Resident #20. At 2:50 P.M., she was noted to be asleep in her bed.</p> <p>On 10/06/2015 from 8:39 A.M. to 12:05 P.M., Resident #20 remained in her room, in her bed. Twice she was noted to look uncomfortable and was making "grunting" noises, however CNA (Certified Nursing Assistant) #55 and LPN (Licensed Practical Nurse) #51 indicated she would occasionally make noises and no care was given. The lights in the room were turned off around 9:56 A.M.</p> <p>On 10/06/15 at 1:03 P.M., Resident #20</p>			

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	<p>was noted to still be in her bed in a darkened room. During an interview, CNA #55 indicated the resident only got out of bed on Mondays, Wednesdays and Fridays.</p> <p>During an interview on 10/07/15 at 11:00 A.M., Activities Assistant, Employee #56, indicated Resident #20 participated in the "Mod Squad" activities when she was up in her chair and he also went to the lounge when she was up to "do sensory/tactile type activities with her. He indicated he spent about 5 minutes with Resident #20 per day doing activities. He indicated Resident #20 did watch the television in the day lounge when she was up in her chair. When asked what stimulation she had when she was in her bed he indicated sometimes she had chaplain visits by the other activity employee. When asked if Resident #20 had participated in the "Mod Squad" group activity on 10/05/15, Employee #56 indicated she had not because she was watching television in the unit lounge. Although Resident #20 had been documented to have daily participated in cognitive, independent, reminiscing/discussions, sensory, social, and television activities, these were not observed.</p> <p>2. The clinical record for Resident #27</p>			

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	<p>was reviewed on 10/05/2015 at 11:26 A.M. Resident #27 was admitted to the facility, on 02/02/15, with diagnoses, including but not limited to: hypertension, hypothyroidism, congestive heart failure, pain, Alzheimer's dementia, depression, venous insufficiency with edema, osteoarthritis and muscle weakness.</p> <p>An Initial Quality of Life Lifestyle Review, completed on 02/03/15, indicated the resident's interests were cooking/food activities, inspirational/religious services or events, needlework, plays piano, crossword puzzles, books, newspapers and magazines. A handwritten note indicated the following: "voices preference to spend time in room. reading and doing cross word puzzles. Staff to ensure she has material to pursue interest. Declined initial offer of library books, will continue to offer. Placed on 1:1 for socialization as res is declining social activities at this time. Voiced past interest in cooking and sewing. States she play piano. Writer asked her to play sometime and she agreed. Care plan in place..."</p> <p>A care plan, related to activities, updated on 08/19/15, indicated the resident had the potential for social isolation, did not</p>			

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	<p>initialize social interaction, preferred to spend time alone, refuses to attend schedule activities, had decreased strength, was a new admit, and had little pleasure or interest in doing thing. The goal was for the resident to attend two group activities a week, express satisfaction with type of activities and level of activity, participate in self-directed activities and accept 1:1 visits 1 times a week. The interventions included: provided 1:1 visits per 1:1 assessment recommendation, provide leisure supplies for self-directed activities per resident interests - offer library books, newspaper, crossword puzzle books, invite to scheduled activities, provide monthly calendar, provide variety of activities and locations, assist to Activity location as needed, remind/assure resident they may leave activity at any time, voiced activities of interest: cooking, sewing, reading, some news, crossword puzzle, pays piano.</p> <p>A care plan, updated on 09/02/15 indicated the resident had a decreased sense of initiation, preferred to stay in her room, and tired easily. The interventions included: use resident's strength and positive coping skills, supports residents efforts to visit, share her likes, interests, introduce resident to others with similar interests, invite/encourage/remind/escort</p>			

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	<p>to activity program consistent with resident's interests, give positive reinforcement as initiate/involvement, improves/attempts to solve conflicts, encourage family/friends to remain involved, monitor need for psychological/psychiatric services, discuss spiritual issues with resident/family/responsible party, discuss with resident feeling, reminiscence, issues, and arrange for clergy or spiritual leader of choice.</p> <p>A quarterly MDS assessment, completed on 09/14/15 indicated the resident scored a 9 of 15 on a BIMS assessment (Brief Interview for Mental Status), was moderately cognitively impaired. The resident required extensive staff assistance of two staff for bed mobility and personal hygiene and had no behavior issues.</p> <p>Resident #27 was observed on 10/02/15, from 8:56 A.M. to 11:15 A.M. and again at 1:25 P.M., lying in her bed. She was awake most of the time, looking out into the hallway with no independent activity or visitors.</p> <p>Resident #27 was observed on 10/05/15 from 8:45 A.M. to 11:52 A.M. lying in her bed. She was awake from 8:45 A.M. to 11:03 A.M. At 11:03 A.M., she fell</p>			

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	<p>asleep and remained asleep at 11:52 A.M. There was no activities, supplies for self directed activities in reach, or visitors noted in her room. She would converse and seemed appreciative of conversation when engaged She was noted to be very confused and had limited short term memory. At 1:13 P.M., she was noted to be asleep with the meal tray on the overbed table in front of her. She remained in her room with no activities from 1:13 PM to 2:50 P.M.</p> <p>Resident #27 was observed, on 10/06/15 from 8:39 A.M. to 12:05 P.M., lying in her bed, on her back without any activities, self-director materials in reach, or visitors other than nursing staff providing care. The resident was noted to engage in conversation when approached but was very confused.</p> <p>The Activity participation logs for Resident #27 indicated she was documented as actively attending or actively participating in 9 different activities per day in September and 6 daily activities in October.</p> <p>During an interview on 10/07/15 at 11:00 A.M., Activity Assistant, Employee #56, indicated he stopped in to converse with Resident #27 for approximately 5 minutes once a day so that accounted for</p>			

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	<p>4 of the activities documented. He indicated the resident fed herself meals which accounted for the independent activity. Employee #56 also indicated the chaplain visited the resident once a week for 1:1 visits and read the Bible with her. Employee #56 indicated 5 minutes per day was not a lot of activities but indicated the resident could read her Bible on her own and he had been "trained" to document multiple activities for his one 5 minute visit per day.</p> <p>3. On 10/5/15 at 9:15 A.M., a review of the clinical record for Resident #4 was conducted. The record indicated the resident was admitted on 9/28/12. The resident's diagnoses included, but were not limited to: lack of coordination, dementia with behaviors, anxiety and cardiac pacemaker.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 8/17/15, indicated the resident had short and long term memory problems. The assessment indicated the resident had moderately impaired skills for daily decisions.</p> <p>An Annual Quality of Life Lifestyle Review, dated 8/4/15, indicated the resident activities were animals, children, inspiration/religious services, and music (singing/choirs). A review comment</p>			

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	<p>section indicated the resident "displays very little interest other than sitting in sunshine."</p> <p>An Annual Social Service Review, dated 8/17/15, indicated the resident was involved in activities "if invited &amp; kept involved" had short attention span and would leave activities.</p> <p>An Activity care plan, dated 8/4/15 and reviewed on 9/9/15, indicated the resident had altered activity pattern related to dementia with behavioral disturbance, severe cognitive impairment - requires 85-100% cognitive assistance for participation. The interventions included, but were not limited to: provide leisure supplies for self-directed pursuits per resident's preferences, enjoys office supplies, church, stories, assist to activity area and invite to mod squad.</p> <p>The following observations were made: -On 10/5/15 at 9:00 A.M. thru 11:47 A.M., Resident #4 was observed sitting in the lounge area in in a padded wheel chair unit he was taken to the dining room -On 10/5/15 at 12:53 P.M., the resident was observed in his room. -On 10/5/15 at 1:15 P.M. thru 4:15 P.M. resident was observed propelling himself up and down the hallways.</p>			

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	<p>-On 10/6/15 at 10:00 A.M., the resident was observed coming from the shower room.</p> <p>-On 10/6/15 at 10:15 A.M., the resident was observed sitting in his wheel chair, in front of the nurse's station.</p> <p>-On 10/6/15 at 10:45 A.M., the resident was observed on another unit propelling himself in a wheel chair and continued to propel himself between the North and South Units unit he was taken to the dining room for lunch.</p> <p>The Event Calendar for October 2015 indicated on 10/5/15 the following activities occurred: "... 10:15 LRC, 12:00 Daily Chronicles, 12:30 Mod Squad, 1:15 Sensory group, 1:30 Euchre club, 2:00 coffee with Lavon, 2:30 Trivia game and 3:45 Rock-O game. On 10/6/15 the following activities were to occur: 10:30 BUM daycare, 12:00 Daily Chronicles, 12:30 Mod Squad, 1:30 Laugh it up, 2:00 Bingo, 3:30 Wii Games and 7:00 Life Stories...."</p> <p>On 10/7/15 at 2:33 P.M., an interview was conducted with the Activity Assistant and the Administrator. The Administrator indicated the facility currently had no Activity Director. The Activity Assistant indicated Resident #4 attended daily a group activity called "Mod Squad." The activity assistant</p>			

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	<p>indicated the resident received all his activities listed on the "Daily Participation Log" during a Mod Squad activity conducted after lunch for 30 minutes with 8 to 11 other residents.</p> <p>4. On 10/5/15 at 9:30 A.M., a review of the clinical record for Resident #16 was conducted. The record indicated the resident was admitted on 9/1/13. The resident's diagnoses included, but were not limited to: joint shoulder pain, diabetes, Alzheimer's disease, muscle weakness, anemia dementia and peripheral vascular disease.</p> <p>The most current assessment regarding the resident's activities was an Initial Quality of Life Lifestyle Review, dated 5/28/14, and a form titled "Pleasant and Meaningful Activity, dated 7/2/15. Both indicated the resident enjoyed activities such as games, animals, art, cooking/food, current events, plants, mystery books, watching baseball and watching TV. There were no current assessments regarding the residents current interests or activity level.</p> <p>A Quarterly Minimum Daily Set (MDS) Assessment, dated 7/2/15, indicated the resident had a BIMS score of 7, a severe cognitive impairment.</p>			

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	<p>An Activity care plan, dated 2/26/15 and updated 9/11/15, indicated the resident had impaired cognition, potential for social isolation and prefers a fixed daily routine. The interventions included, but were not limited to: provide leisure supplies for self-directed activities-art supplies, pets, children, invite to scheduled activities and invite to activities which promote additional intake of foods/fluids.</p> <p>An Activities of Daily Living (ADLs) care plan, dated 3/3/15 and reviewed on 8/28/15, indicated the resident was assisted with transfers, dressing, personal hygiene and bathing. The interventions included, but were not limited to: adaptive/safety equipment-walker, turn/reposition, shifting weight to enhance circulation and invite, encourage, remind and escort to activity programs.</p> <p>A Social Service Review, dated 10/2/15, indicated the resident had a BIMS score of 6 and required cues/prompts to follow simple directions. The review further indicated the resident was involved with activities such as: movies, arts/crafts, coloring, music events, holding a doll/stuffed animals.</p> <p>The following observations were made:</p>			

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	<p>-On 10/1/15 at 1:39 P.M., an activity game was being played in the lounge are of the dementia unit. The resident was observed lying in her bed, with a few dolls.</p> <p>-On 10/5/15 at 9:01 A.M., the resident was observed sitting in a chair, at a table.</p> <p>-On 10/5/15 at 10:15 A.M., the resident was observed in her bed talking with two dolls while an activity was going on in the lounge. The resident had not been invited to participate</p> <p>-On 10/5/15 at 10:58 A.M., the resident was observed asleep in her bed, while the reading of the "Daily Gazette" was being conducted.</p> <p>-On 10/5/15 at 11:23 A.M., the resident was observed walking with a walker, down the hallway toward the dining area. The resident was assisted with sitting in her chair. The resident was given coffee and was seen talking with another resident sitting next to her. At 11:50 AM meal service started.</p> <p>-On 10/5/15 at 1:05 P.M., the resident was observed walking with her walker toward her room with stand by assistance given by CNA #14</p> <p>-On 10/5/15 at 1:47 P.M., the resident was observed lying in bed with her eyes open. The activity of coloring was being enjoyed by two residents and LPN #15. The resident had not been invited to participate in the activity.</p>			

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	<p>On 10/5/15, Observations were made, on the Serenity/Dementia Unit from 9:00 A.M. thru 3:30 P.M. and none of the activities listed on the calendar for 10/5/15 had been conducted.</p> <p>-On 10/6/15 at 10:11 A.M., resident was in her bed with her eyes closed. Other residents were in the lounge area with TV on.</p> <p>The Serenity Events Calendar indicated on Monday October 5th the following activities were scheduled: Trivia, Comedy Hour, Nature Talks, Sewing Club, Bingo, Color Me Crazy and Memory Lane. Daily Activities were: AM Stretch to Music, Meal Prep w [with] /coffee &amp; socialization, daily bread devotional reading and independent activity.</p> <p>A Daily Participation Log, dated October 2015, indicated the resident was not involved in any activities 10/3 (Saturday) and 10/4 (Sunday). The activity log indicated the resident was actively involved in the following activities on Monday 10/5/15: movies/videos, reading activity (group), reminiscing/discussions, reading/talking books, sensory/awareness, trivia/quizzes and walk/wheelchair ride.</p> <p>On 10/7/15 at 2:33 P.M., an interview</p>			

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	<p>was conducted with the Activity Assistant and the Administrator. The Administrator indicated the facility currently had no Activity Director and the CNA's on the Serenity Unit were conducting the activities and completing the Participation Logs for the dementia residents. The Activity Assistant could not explain why the activity schedule wasn't being followed. The Administrator indicated a new Activity Director had been hired and would be starting soon.</p> <p>5. On 10/6/15 at 10:00 A.M., a review of the clinical record for Resident #28 was conducted. The record indicated the resident was admitted on 6/16/15. The resident's diagnoses included, but were not limited : dementia w/o [without] behavior disturbance, atrial fibrillation, hypertension renal failure and depressive disorder.</p> <p>An Activity care plan, dated 9/9/15, indicated the resident had little interest or pleasure in doing things related to cognition, dementia, behaviors and decreased strength. The interventions included but were not limited to: provide leisure supplies for self-directed activities per resident interest-pictures to color/paint, invite resident to scheduled activities, and provide a variety of</p>			

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	<p>activities. A behavior care plan dated 6/19/15 and reviewed on 9/10/15, indicated the resident was physically/verbally abusive, socially inappropriate and resisted care. One of the interventions listed indicated to invite/encourage the resident to the activity programs consistent with her interests. Another care plan indicated the resident was depressed with an intervention to invite/encourage/remind/escort resident to activity programs consistent with her interests.</p> <p>A 60 day MDS Assessment, dated 8/11/15, indicated the resident's BIMS score was 6, severe cognitive impairment.</p> <p>The following observations were made:</p> <ul style="list-style-type: none"> <li>-On 9/30/2015 at 11:30 A.M., the resident observed sitting in wheelchair, sleeping, in the Serenity Unit lounge area</li> <li>-On 10/1/2015 at 9:03 A.M., the resident was sleeping in bed.</li> <li>-On 10/1/15 from 9:25 A.M., the resident was sitting in wheelchair in her room.</li> <li>-On 10/1/15 from 9:46 A.M. thru 11:15 A.M., the resident was sitting in her wheelchair, in the Serenity Unit and wasn't participating in an activity.</li> <li>-On 10/5/15 at 9:03 A.M., resident was observed sitting in the activity room in a</li> </ul>			

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	<p>padded w/c. The resident's eyes were open and a TV was on but she was not watching the TV.</p> <p>-On 10/5/15 at 10:12 A.M., the resident was observed sitting in lounge area when LPN #15 started an activity of throwing/bouncing a beach ball to the residents. Resident #28 did not participate.</p> <p>-On 10/5/15 from 10:33 A.M. thru 11:50 A.M., the resident was not seen participating in an activity.</p> <p>-On 10/6/15 at 10:10 A.M., no activities were being conducted. TV was on and resident was facing into dining area. At 10:12 A.M., CNA #14 propelled the resident to the other side of room and placed her in front of the TV and told her "lets watch the TV and you tell me what the movie is about", the CNA walked away. The resident moved her back forward and an alarm sounded CNA #14 returned to the area, told the resident lets take a walk. CNA #14 propelled the resident just inside the hallway and left resident in the hallway and went into another room. CNA #14 returned to the resident and took her down the short hallway, and back stopping at a side door to look out the window and returned the resident at 10:16 A.M., to activity room and placed her in the same area of the room, facing the TV.</p>			

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	<p>The Serenity Events Calendar indicated on Monday October 5th the following activities were scheduled: Trivia, Comedy Hour, Nature Talks, Sewing Club, Bingo, Color Me Crazy and Memory Lane. Daily Activities were: AM Stretch to Music, Meal Prep w/coffee &amp; socialization, daily bread devotional reading and independent activity. The Serenity (Dementia Unit) Events Calendar indicated on Tuesday October 6th the following activities were schedule to occur: Sports time, choice movie/snack, hand massages, painting, music appreciation, horse races and poets corner.</p> <p>6. On 10/6/15 at 9:10 A.M., a review of the clinical record for Resident #82 was conducted. The record indicated the resident was admitted on 9/28/15. The resident's diagnoses included, but were not limited :urinary tract infection, dementia with behavioral disturbance, depressive disorder, glaucoma and neurogenic bladder.</p> <p>An Initial Quality of Lifestyle Review, dated 10/2/15, indicated the resident had no animals at home but liked dogs, he liked collecting anything, he loved hunting/fishing, watching old cowboy shows and the couple had done some traveling.</p>			

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	<p>An Activity Care Plan, dated 10/2/15, indicated the resident's previous recreational interests included daily contact with close friends and/or relatives and resident had potential for altered activity pattern related little or no involvement in activity programs. The goal was for resident to attend group activity of interest once a week. Interventions/approaches included but were not limited to: invite to scheduled activities, offer variety of activity types/locations, likes to watch old cowboy movies, traveled a lot, enjoys music and outdoorsman.</p> <p>A MDS admission 5 day assessment, dated 10/5/15, indicated the resident was not able to complete an interview for the assessment for mental status.</p> <p>Another care plan for cognitive loss, dated 9/30 with update on 10/5/15, indicated the resident had impaired cognitive skills, as evidenced by decision making problem, short/long term memory problem and problem understanding others related to Alzheimer disease. The interventions included but were not limited to: provide orientation, invite, encourage remind and escort to activity programs consistent with resident's interest and provide cues, and prompting.</p>			

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	<p>The Serenity Events Calendar indicated on Monday October 5th the following activities were scheduled: Trivia, Comedy Hour, Nature Talks, Sewing Club, Bingo, Color Me Crazy and Memory Lane. Daily Activities were: AM Stretch to Music, Meal Prep w/coffee &amp; socialization, daily bread devotional reading and independent activity.</p> <p>The following observations were made on 10/5/15: On 10/5/15 at 9:03 A.M., Resident #82 was observed sitting in a wheel chair in the hallway. At 9:06 A.M., the resident was propelled into the lounge area and asked if he liked to watch a TV program and the resident didn't respond. At 9:15 A.M., LPN #15 started bouncing/throwing a beach ball to the resident's. Resident #82 refused to participate. At 10:33 A.M., the resident was taken to his room by the Social Service Director to conduct an interview for a MDS assessment. The resident was brought back to lounge area at 10:37 A.M. and was positioned in front of the TV. At 10:54 A.M., the TV was turned to mute and a staff member started reading "Monthly Gazette." The resident was still facing the TV and not the reader. At 11:26 A.M., the resident was</p>			
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	<p>observed sitting in his wheel chair facing the TV, the sound was now on. Resident was not watching the program. At 11:32 A.M., resident was observed propelling himself down the hallway. At 11:34 A.M., the resident was observed being propelled by staff member to dining room. The resident was observed taking a drink of his milk. At 11:50 A.M., meal service started. On 10/5/15 at 1:31 P.M., the wife returned the resident to the lounge area and resident remained in his wheel chair with his feet up on a chair until the last observation was made at 3:15 P.M.</p> <p>The following observations were made on 10/6/15:</p> <ul style="list-style-type: none"> <li>-At 10:10 A.M., the resident was observed in the lounge area, sitting in a w/c with his eyes closed facing the TV. An old western movie CD was playing on the TV.</li> <li>-At 10:30 A.M., QMA (Qualified Medication Aide) #17 came into the room and change TV program.</li> <li>-At 10:45 A.M., QMA #17 propelled the resident into the dining room, and place his w/c in front of a table. The QMA was sitting at the same table, but did not speak to the resident.</li> </ul> <p>The Serenity (Dementia Unit) Events Calendar indicated on Tuesday October</p>			

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F 0280	<p>6th the following activities were schedule to occur: Sports time, choice movie/snack, hand massages, painting, music appreciation, horse races and poets corner.</p> <p>On 10/7/15 at 1:15 P.M., the Administrator provided a policy titled "Activity Program", dated August 2007 and revised on January 2009, and indicated the policy was the one currently used by the facility. The policy indicated "...1. The activity program is designed to encourage each individual resident to be the highest functioning level possible physically, cognitively, emotionally as well as meet their needs and interests...2. Activities are scheduled daily...."</p> <p>3.1-33(a)</p> <p>.</p> <p>483.20(d)(3), 483.10(k)(2)</p>			

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SS=D Bldg. 00	<p><b>RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b></p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, record review and interviews, the facility failed to ensure a behavior plan was updated to include a resident's behavior of transferring other residents for 1 of 1 residents reviewed for behaviors. (Resident #65) In addition, the facility failed to ensure a care plan regarding vision needs was updated for 1 of 2 residents reviewed for vision needs. (Resident #4) The facility also failed to ensure a care plan regarding contracture/splint needs was updated for 1 of 3 residents reviewed for range of motion issues. (Resident #59)</p> <p>Findings include:</p>	F 0280	It is the intent of this facility to develop a comprehensive care plan to describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and to update it in accordance with any changes identified by staff, family, or IDT team. 1. Residents #65, #4, #59 care plans and CNA care cards were updated immediately to reflect current interventions. 2. 100% audit of Resident Care plans was completed by IDT to ensure accuracy of current treatment plans and resident choices. 3. SCC will educate the IDT team regarding the timely updating of care plans with any changes of resident status.	11/06/2015

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	<p>1. The clinical record for Resident #65 was reviewed on 10/07/2015 at 2:57 P.M. Resident #65 was admitted to the facility on 08/28/13 with diagnoses, including but not limited to non-Alzheimer's dementia, hypertension, and anemia.</p> <p>A reportable fall investigation, completed on 08/14/15, indicated on 08/13/15 at 5:17 P.M., Resident #33 was found on the floor. The incident report and investigation indicated Resident #65 had turned off the wheelchair alarms and unfastened a seatbelt for Resident #33 and had attempted to assist Resident #33 to transfer to the toilet. Resident #65 had then alerted CNA (Certified Nursing Assistant) #57 when Resident #33 had fallen to the floor.</p> <p>The nursing progress notes for Resident #65 on July 16, 23 and 31, 2015, indicated the resident had been observed attempting to help other resident's to the bathroom or to bed and had to be redirected. Resident #65 would become very upset when redirected from that activity.</p> <p>The behavior tracking for Resident #65 for August and September 2015, indicated the resident was being monitored for delusions, yelling at other, pacing, and tearfulness. There was no</p>		Licensed Nurses have been re-educated by SDC/ designee on policy and procedure with regards to care plan updates. 4. PI tool has been developed to monitor compliance related to care plan updates to be completed by DON/ designee weekly x 4 and then monthly x 3 and quarterly thereafter, until the QAPI committee determines that 100% substantial compliance is consistently being achieved.	

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	<p>care plan initiated specific to the resident's behavior of attempting to assist other residents with transferring and toileting needs.</p> <p>2. On 10/5/15 at 9:15 A.M., a review of the clinical record for Resident #4 was conducted. The record indicated the resident was admitted on 9/28/12. The resident's diagnoses included, but were not limited to: lack of coordination, dementia with behaviors, anxiety and cardiac pacemaker.</p> <p>A fall risk evaluation, dated 8/5/15, indicated the resident's vision status was "...moderately impaired-limited vision, but can identify objects...."</p> <p>The Annual Minimal Data Set (MDS) assessment, dated 8/17/15, indicated the resident had impaired vision but had no corrective lenses.</p> <p>A Vision Care plan, dated 3/31/15 and reviewed on 9/2/15, indicated the resident had vision loss related to dementia/Alzheimer. The resident's goal was to demonstrate ability to compensate for visual loss as evidenced by wearing glasses daily. The interventions included but were not limited to: place, offer/remind to resident to wear glasses daily, clean/maintain glasses daily as</p>			

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	<p>needed and make sure glasses are within reach.</p> <p>An untitled form with resident's picture on it, dated 2015, showed the resident with glasses on, however the form indicated "no longer wear glasses."</p> <p>A Care Plan Conference Summary, dated 9/9/15, indicated under the vision section resident "wears glasses."</p> <p>The resident was observed the following dates and times with no glasses: 10/5/15 at 9:00 A.M. 10/5/15 at 4:11 P.M. 10/6/15 at 9:10 A.M. 10/6/15 at 1:10 P.M.</p> <p>During an interview, on 10/6/15 at 2:55 P.M., CNA #10 indicated the resident wore glasses.</p> <p>During an interview, on 10/6/15 at 3:05 P.M. the Social Services Director indicated the resident wanders the facility and may of taken his glasses off and left them somewhere. The Social Service Director was observed trying to find them in the resident's room.</p> <p>During an interview, on 10/6/15 at 3:10 P.M., the Director of Nursing (DON) provided a current nursing aide work</p>			

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	<p>sheet, dated 10/2/15, and indicated the resident did not wear glasses anymore, as glasses was not mark on the work sheet. The DON indicated the vision care plan had not been updated to reflect the resident's non use of his glasses. She further indicated the Social Service Director was responsible to change the care plan to reflect the residents non use of his glasses.</p> <p>The Social Service Director provided an Annual Social Service Review, dated 8/17/15. The Progress Note indicated a plastic cover over the temple (ear) was missing and daughter did not want the resident to wear them. The same Progress Note indicated the glasses were place in the Social Service Director's office in an envelope. The Social Service Review indicated the resident had "vision impairment-no longer wears his glasses." The Social Service Director indicated she was not the one who would update the care plan regarding the resident's vision.</p> <p>On 10/7/15 at 1:30 P.M., the DON provided a policy titled "Care Plans-Comprehensive", dated 10/2010, and indicated the policy was the one currently used in the facility. The policy indicated "...Revisions 8. Assessments of residents are ongoing and care plans are revised as information about the resident</p>			

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	<p>and the resident's condition change...."</p> <p>3. The clinical record for Resident #59 was reviewed on 10/5/15 at 9:37 A.M. Resident #59 was admitted to the facility, on 3/14/14, with diagnoses, including but not limited to: Parkinson's disease, paralysis, senile dementia, joint contracture of the hand and forearm and depressive disorder.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 8/12/15, indicated the resident had severe cognitive impairment with a score of 4 out of 15 on the BIMS (Brief Interview for Mental Status), required extensive 2 person assist with bed mobility, dressing and personal hygiene and extensive 1 person assist with eating.</p> <p>A physician order, dated 5/27/14, indicated left upper extremity splint required to reduce further development of a contracture.</p> <p>An Occupational Therapy evaluation, dated 4/14/15, indicated the reason for the referral was due to a decline in self feeding skills, an increased need for assistance from others and a decrease in strength indicating the need for OT (Occupational Therapy) to assess the need for adaptations and to maximize</p>			

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	<p>rehab potential. The resident has not been using his splint and appears to be having more contracted joints to the left forearm. Impression: Patient has not been using the splint for his left forearm and is in the process of developing a fixed contracture. Due to the documented physical impairments and associated functional deficits, the patient is at risk for behavioral outbursts, contracture(s), decreased participation with functional tasks, decreased skin integrity, increased agitation and increased tone, limiting functional movement.</p> <p>An Occupational Therapy discharge summary, dated 5/13/15, indicated the patient refuses the splint to the left hand, but is compliant with the carrot orthosis. Patient is easily agitated when receiving interventions, but if everything is explained well, then the patient tolerates well. Discharge recommendations: patient is to have the carrot orthosis in the left hand except when engaged in activities. PROM (passive range of motion) needs to be performed to the BUE (bilateral upper extremity) to maintain current ROM (range of motion) to enable the patient to continue with self feeding and leisure tasks such as using the remote control.</p> <p>A Rehab Communication Slip, dated</p>			

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	<p>5/29/15, indicated the type of change/recommendation: 1. the splint for the L (left) hand has been dc'd (discontinued) d/t (due to) pt (patient) refusal to tolerate. 2. Patient is to have an ortho carrot in the L hand. To be removed for meals, hygiene etc. Persons notified: Nursing.</p> <p>A care plan, dated 5/28/14 and revised on 8/13/15, indicated the resident had increased tone to the left hand/wrist which places (resident name) at risk for contractures. Interventions included, but were not limited to: Occupational therapy as ordered. Observe the skin when applying or removing splints. Report red, rashy, irritated or open areas to the nurse. Apply splints as ordered. Observe for s/sx (signs or symptoms) of pain such as grimacing, moaning, and fidgeting with the splints. Observe for changes in functional use or ROM to hand/arm and notify the nurse. Keep MD (Medical Doctor) informed.</p> <p>A Request for Therapy Evaluation form, dated 10/1/15, indicated from a nursing assessment the resident has had a recent change in the ability to tolerate the carrot as evidenced by: refusing to wear the carrot on LUE (left upper extremity). OT (Occupational Therapy) to d/c carrot to LUE. Nursing to complete PROM to UE</p>			

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	<p>(upper extremity).</p> <p>A behavior/intervention monthly flow record, dated October 1 to 5, 2015, indicated behavior #1: combative with care, there was no documentation of the resident being combative with care for the day, evening or night shift. Behavior # 3: refusing meals, care and meds, there was no documentation of the resident refusing care on day, evening or night shift from October 1 to 5, 2015.</p> <p>On 10/1/15 at 10:19 A.M., Resident #59 was seated in his wheelchair in the resident lounge. The resident had a lap blanket draped across his lower extremities. His left hand and fingers are contracted, no splint or carrot orthotic was observed.</p> <p>On 10/5/15 at 10:33 A.M., Resident #59 was observed seated in his wheelchair in his room watching the television. His left hand and fingers are contracted and no splint or carrot orthotic was observed in his hand.</p> <p>On 10/6/15 at 9:10 A.M., Resident #59 was assisted back to bed by CNA #1 and CNA #2 and the use of a Hoyer lift (a mechanical lift). CNA #1 indicated to the resident she wanted to open his fingers on his left hand to look at the palm of his</p>			

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	<p>hand, as CNA #1 attempted to bend the residents fingers out straight the resident grimaced as if in pain and attempted to hit CNA#1 with is right hand. No open areas were observed on the palm of the residents left hand. During an interview at that time with CNA#1, she indicated the resident refuses to wear the carrot orthotic because it is uncomfortable and he becomes combative at times with care. She further indicated she performed ROM on the residents left hand and fingers when she gave him a shower this morning.</p> <p>During an interview, on 10/6/15 at 9:55 A.M., the DON (Director of Nursing) indicated the resident refuses to wear the carrot orthotic anymore so the orthotic was discontinued on 10/1/15. She further indicated listed on the resident care sheet under the special needs section for this resident there are instructions for the CNA's to wash and dry the his hand every shift. The DON indicated the expectation would be that the staff would do PROM to the hand and fingers when they wash the hand. The DON indicated there was not a specific place for the staff to document when PROM has been completed.</p> <p>During an interview, on 10/6/15 at 10:15 A.M., the DON indicated the care plan</p>			

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	<p>regarding the residents risk for contracture's was not in his chart it had been thinned from the chart and was filed in the medical record department. The DON further indicated the care plan should have been on the residents chart and the interventions should have been updated.</p> <p>During an interview, on 10/6/15 at 10:41 A.M., the Occupational Therapist, Employee #3, indicated she was not made aware the resident was refusing to use the carrot orthotic in his left hand until 10/1/15, when a staff nurse informed her that "he just won't wear it and flat out refuses it and will swing at staff when they try to apply the carrot orthotic." She further indicated she had not worked with the resident since his discharge in May of 2015, and at that time he was using the carrot orthotic. She indicated as long as staff approach him in a calm manner and explain things prior to doing it he will allow you to work with his hand.</p> <p>On 10/7/15 at 2:00 P.M., the DON provided a policy titled "Care Planning," dated February 2014, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Each resident's comprehensive plan is designed to:...g. aid in preventing or reducing declines in the resident's functional status</p>			

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F 0282 SS=D Bldg. 00	<p>and/or functional levels...5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers...8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change...9. The care planning/ Interdisciplinary Team is responsible for the review and updating of the care plans:</p> <p>a. When there has ben a significant change in the resident's condition. b. When the desired outcome is not met...d. At least quarterly...."</p> <p>3.1-35(d)(2)(b) 3.1-35(f)</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</p>			

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	<p>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 care plans were followed regarding toileted needs for 1 of 3 residents reviewed for incontinence (Resident #45). In addition, the facility failed to ensure the care plans were followed for 1 of 3 residents regarding pressure ulcer prevention and/or incontinence care needs. (Resident #27) The facility also failed to follow an activity care plan for 1 of 7 resident reviewed for activity needs. (Resident #20)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #20 was reviewed on 10/05/2015 at 9:45 A.M. Resident #20 was admitted to the facility, on 04/01/14, with diagnoses, including but not limited to: cerebral vascular accident, diabetes, aphasia, convulsions, hypertension, dysphagia, esophageal reflux, constipation and contracture's at multiple joints.</p> <p>A quarterly activity note, completed on 08/05/15 indicated the resident received 1:1 visits 2 x (times) a week, and sensory group 3 x week to continue for social and sensory stimulation. The note indicated the resident had been noted to have an</p>	F 0282	<p>It is the intent of our facility that all services provided will be in accordance with each resident's written plan of care. 1. Care plans for Resident #27, #20 and #45 were reviewed and C.N.A care cards have been updated, and are currently being followed by facility staff. 2. 100% of Resident Care plans have been reviewed to ensure that they reflect resident's current status. C.N.A care cards have been updated and are currently being followed. 3. Licensed Nursing staff, C.N.A and IDT have been re-educated by SDC/ designee regarding facility policy and procedure and following the resident's plan of care. 4. PI tool has been developed to monitor compliance with regards to following the resident's plan of care to be completed by DON/designee weekly x4, monthly x 3 and will be presented by the DON/ Designee to the QAPI meeting monthly x 3 and quarterly thereafter, until the QAPI committee determines substantial compliance has been achieved.</p>	11/06/2015

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	<p>increase in her response with more vocalizing and more tracking with her eyes. The note also indicated the resident's family and Hospice visited with her.</p> <p>A care plan related to psychosocial well-being, reviewed as current on 08/05/15 indicted activities were to be provided in group setting, independently, and 1:1 room visits, the activities were to accommodate resident loss such as cognitive, mobility, vision or hearing, provide for ability to attend functions outside of room as tolerated, evaluate for change of room placements when roommate conflict exists, and keep center for Hospice and family updated on condition and changes."</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 08/12/15, indicated the resident was severely cognitively impaired, required total staff assistance for wheelchair locomotion, transfers and ADL's (Activities of Daily Living). The resident was always incontinent of her bowels and bladder. The resident was at risk for developing pressure ulcers but had no pressure ulcers.</p> <p>Resident #20 was observed to be lying in her darkened room, in her bed, on</p>			

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	<p>10/05/2015 from 8:45 A.M. to 11:53 A.M. At 11:53 A.M., she was transferred into a Broda reclining wheelchair and left in her room. There was no activities or any kind of stimulation provided for Resident #20 other than incontinence care, which was provided at 11:03 A.M.</p> <p>On 10/05/15 at 1:13 P.M., Resident #20 was observed to be in her Broda chair in the day lounge beside the television. The room was darkened, the blind were pulled, and the television was playing an old black and white movie. The resident was noted to remain in the day lounge by the television from 1:13 P.M. to 1:30 P.M. Other than the television, there was no other stimulation provided to Resident #20. At 2:50 P.M., she was noted to be asleep in her bed.</p> <p>On 10/06/2015 from 8:39 A.M. to 12:05 P.M., Resident #20 remained in her room, in her bed. Twice she was noted to look uncomfortable and was making "grunting" noises, however CNA (Certified Nursing Assistant) #55 and LPN (Licensed Practical Nurse) #51 indicated she would occasionally make noises and no care was given. The lights in the room were turned off around 9:56 A.M.</p> <p>On 10/06/15 at 1:03 P.M., Resident #20</p>			

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	<p>was noted to still be in her bed in a darkened room. Interview with CNA #55 indicated the resident only got out of bed on Mondays, Wednesdays and Fridays.</p> <p>During an interview on 10/07/15 at 11:00 A.M., Activities Assistant, Employee #56, indicated Resident #20 participated in the "Mod Squad" activities when she was up in her chair and he also went to the lounge when she was up to do sensory/tactile type activities with her. He indicated he spent about 5 minutes with Resident #20 per day doing activities. He indicated Resident #20 did watch the television in the day lounge when she was up in her chair. When asked what stimulation she had when she was in her bed he indicated sometimes she had chaplain visits by the other activity employee. When asked if Resident #20 had participated in the "Mod Squad" group activity on 10/05/15, Employee #56 indicated she had not because she was watching television in the unit lounge. Although Resident #20 had been documented to have daily participated in cognitive, independent, reminiscing/discussions, sensory, social, and television activities, these were not observed.</p> <p><b>2.</b> The clinical record for Resident #27 was reviewed on 10/05/2015 at 11:26</p>			

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	<p>A.M. Resident #27 was admitted to the facility on 02/02/15 with diagnoses, including but not limited to: hypertension, hypothyroidism, congestive heart failure, pain, Alzheimer's dementia, depression, venous insufficiency with edema, osteoarthritis and muscle weakness.</p> <p>Physician progress notes indicated the resident has an infected skin rash with cellulitis to the right lower extremity in September 2015.</p> <p>A quarterly MDS assessment, completed on 09/14/15, indicated the resident required extensive staff assistance of 2 for bed mobility and personal hygiene, was always incontinent of her bowels and bladder, was at risk for pressure ulcers but had no pressure ulcers.</p> <p>There was a care plan related to the resident's risk for developing pressure ulcers. The interventions were to provide incontinence care after incontinence episodes, avoid prolonged periods of skin to skin contact, monitor labs, provide diet, assist patient with repositioning, provide pressure reduction mattress, position with pillows, turning and repositioning program, encourage use of side rails, maintain pressure over bony prominence's.</p>			

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	<p>On 10/01/2015 from 8:56 a.m. to 11:15 A.M., Resident #27 was observed lying in her bed on her back. She was not noted to be repositioned or assisted to turn.</p> <p>Resident #27 was observed on 10/02/2015 at 2:17 P.M., sleeping in her bed. There was a padded foot cradle on the bed but her feet were beyond the cradle and up against the footboard.</p> <p>On 10/05/15 from 8:45 A.M. to 10:15 A.M., Resident #27 was noted to be lying in her bed, on her back with her feet against the foot board and the foot cradle underneath her knees not floating her heels.</p> <p>On 10/05/15 at 10:21 A.M., the resident was noted to have been pulled up in the bed and her feet were now floated with the foot cradle. She was still positioned on her back. There were no extra pillows or wedge cushion noted in the bed or in the recliner beside her bed. Resident #27 remained in her bed, on her back without any position changed from 10:21 A.M. to 11:53 A.M.</p> <p>On 10/05/15 at 1:13 P.M., Resident #27 was observed sitting up in bed on her back with a meal tray on the overbed</p>			

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	<p>table in front of her. She was asleep and the room smelled like bowel movement. She remained in the same position without any care, except to remove the meal tray from 1:13 P.M. to 2:50 P.M.</p> <p>On 10/06/2015 at 8:39 A.M., Resident #27 was observed sitting up in her bed, on her back with her breakfast tray in front of her on the overbed table. Resident #27 remained in the same position until 9:08 A.M. when LPN #51 changed the dressing on her legs. The foot cradle was not properly positioned and the resident's heels were not floated. Resident #27 remained positioned on her back without her heels floated until 9:56 A.M., when LPN #51 was alerted of Resident #27's concern with her brief being too tight. LPN #51 loosened the tap on the tabs of the briefs but did not reposition the resident. Resident #27 remained in the same position without any assistance from 9:56 A.M. to 12:05 P.M. Interview with CNA #55 indicated Resident #27 had been provided incontinence care "after breakfast" though not observed and would not receive incontinence care until after lunch.</p> <p>On 10/06/2015 at 1:03 P.M. Resident #27 was noted to still be positioned on her back in her bed. CNA #55 was noted</p>			

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	<p>pushing the food cart in the hallway and indicated she had not yet provided incontinence care for Resident #27.</p> <p>Resident #27's skin was observed on 10/06/15 at 1:35 P.M. with CNA's #55 and 58. The resident's brief was saturated with urine and she also had dried bowel movement in it. The resident complained of pain when she was moved about. There were deep indention's in her skin from the brief's elastic edges. There was an open area approximately pencil eraser sized with red tissue at the bottom of the coccyx by the left gluteal fold. The resident was cleaned and again repositioned onto her back.</p> <p>Interview on 10/07/15 at 10:38 A.M. with RN (Registered Nurse) #59 indicated Resident #27 refused to get out of bed or be turned on her side due to pain issues. When queried as to why staff did not obtain better pain medications and control for Resident #27, RN #59 indicated the resident was really not in pain unless she was moved.</p> <p>Although there was a care plan regarding the resident's behaviors of yelling out at staff member which indicated the resident did refuse to get out of bed. The interventions indicated the importance of getting out of bed and moving were to be</p>			

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	<p>stressed but the resident's "choice" was to be respected. There were no specific interventions to provide a way to offload the resident's pressure points and there was no reason given as to why the resident was not receiving incontinence care and/or turning and repositioning as per her care plan.</p> <p>3. On 10/01/15 at 2:21 P.M., Resident #45 was observed seated in his recliner in his room. His wheelchair was located in front of his recliner. The resident's room, especially around where he was seated smelled strongly of urine.</p> <p>The clinical record for Resident #45 was reviewed on 10/05/2015 at 9:02 A.M. Resident #45 was admitted to the facility, on 01/16/14, with diagnoses, including but not limited to: advanced dementia, history of urinary tract infection, history of falls, atrial fibrillation, bradycardia, hypertension, benign prostatic hypertrophy, and long term anticoagulation.</p> <p>The current medication orders for Resident #45 included the medication, Tamsulosin HCL (hydrochloride) for urinary retention issues.</p> <p>An MDS (Minimum Data Set) assessment, competed on 08/1015,</p>			

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	<p>indicated the resident was occasionally incontinent of his bladder.</p> <p>A Braden's assessment for Pressure ulcer risk, completed on 08/05/15 indicated the resident was occasionally moist for skin issues.</p> <p>An admission nursing assessment, Bladder Status Screening assessment, completed on 01/16/14, indicated the resident had no apparent pattern, voided every 2 - 3 hours, was occasionally incontinent, and wore briefs.</p> <p>A Bladder Status Evaluation, completed on 05/08/14, indicated the resident had been incontinent for approximately 2 to 2 1/2 months, used a urinal at night but was "spilling it and sometimes doesn't get to urinal in time." The assessment indicated the resident did not wear a brief but "should..." The resident was assessed with functional incontinence due to poor mobility, arthritis, and dementia. There was no type of toileting program chosen for Resident #45 at the bottom of the form.</p> <p>A care plan related to ADLs (activities of daily living) , initiated on 01/13/15 and reviewed as current on 07/08/15 indicated the resident required assist of one for toilet use. The intervention</p>			

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	<p>indicated "provide only the amount of assistance/supervision that is needed at the time of care" and "Resident requests urinal and refuses to use bathroom. Frequently spills urinal on self, furniture, bedding but does not notify staff."</p> <p>A care plan regarding potential for complications associated with urinary incontinence indicated the resident was frequently incontinent and included the following interventions: "provide/encourage use of adaptive equipment urinal, monitor need/schedule appropriate diagnostic procedure prn, report any change in bladder status to nurse, report change is bladder status to physician prn, monitor labs as ordered and report results to physician, check resident for incontinent episodes, provide peri care after each incontinent episode, encourage resident to get out of bed to bathroom but give urinal if asks."</p> <p>On 10/05/2015 at 8:45 A.M., Resident #45 was not observed in his room. The room smelled of urine. There was a croquet afghan located on the seat of his recliner. A housekeeper was noted to be wiping the hard surfaces in his room with a yellow colored spray.</p> <p>On 10/05/2015 at 9:01 A.M., Resident #45 was noted to be seated in his recliner</p>			

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	<p>in his room with his wheelchair in front of the recliner At 9:35 A.M. he was noted to be standing in front of his recliner, his brief was still in place and he was struggling to pull up his outside pant. CNA #52 was alerted and by the time she arrived in his room, Resident #45 was seated on the end of his recliner and his outside pants were not pulled up to his waist. He requested help getting his pants pulled up properly. CNA #52 assisted him to pull up his pants and seated him back in the recliner with his feet elevated. She indicated he did not seem to have to use the restroom but she did not ask him if he needed any assistance with toileting. She indicated the pants he was wearing were too loose around the waist and must have fallen down when he stood up. She indicated she did not assist Resident #45 with his toileting as he used a urinal by himself.</p> <p>Resident #45 remained in his room sleeping in the recliner until 11:53 A.M. when he was noted to have transferred to the wheelchair and taken himself into the dining room. A small amount of urine was noted in the urinal in his room and the room smelled strongly of urine.</p> <p>On 10/06/2015 at 8:42 A.M., Resident #45 was observed to propel his wheelchair into his room, he stood up,</p>			

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	<p>unfastened his outside pants, which exposed a brief, transferred self to recliner, put his feet up on recliner and pulled a blanket over himself. A few minutes later, he put the foot rest down on the recliner and stated he was going to use the urinal. An empty urinal was noted on the overbed table. The Maintenance Supervisor was noted in Resident #45's bathroom replacing the bathroom flooring. The resident door was shut so he would have privacy to use the urinal.</p> <p>On 10/06/2015 8:48 A.M., Resident #45 was noted to be covered up lying in his recliner. The urinal was empty. Interview with the Maintenance Supervisor who was still in the adjoining bathroom indicated he did not think the resident remembered what he was doing, did not actually use the urinal but just sat back down into the recliner. The Maintenance Supervisor indicated he thought he resident did not always follow through due to his dementia. Resident #45 remained in his recliner asleep from 8:48 A.M. to 11:17 A.M., an empty urinal sat on the overbed table. At 11:28 A.M., a small amount of urine was noted in the urinal which was on the overbed table and the resident and his wheelchair were not in the room. The Maintenance Supervisor, who was in the resident's</p>			

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	<p>bathroom now replacing the toilet, indicated he was not aware of where the resident had gone. The room still smelled strongly of urine and the resident's recliner seat, which had a croqueted afghan on the seat was touched and noted to be damp. The Maintenance Supervisor indicated he knew that room smelled of urine and indicated he would take care of the resident's wet recliner. The resident was located in the therapy room.</p> <p>At 10/06/15 at 11:57 A.M., therapist #53 was noted pushing Resident #45 back into his room. Therapist #53 indicated he had assisted Resident #45 with using the urinal before he was taken to the therapy room. The Maintenance Supervisor informed Resident #45 that his recliner had been "cleaned" and his croqueted afghan was noted in a plastic bag.</p> <p>During an interview with CNA #54, on 10/07/15 at 2:16 P.M., she indicated she did not toilet or assist Resident #45 with toileting needs and he was able to utilize the restroom by himself.</p> <p>A nursing assistant assignment sheet for the South unit, dated 10/02/15, indicated Resident #45 was identified as incontinent, wore extra large pull ups, and "cue resident to use bathroom" was</p>			

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F 0314 SS=D Bldg. 00	<p>also documented on the instruction sheet.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to reposition wheelchair bound residents to promote circulation and provide pressure relief for 3 of 4 wheel chair bound assessed at risk for skin breakdown. (Resident #4, #28, #82)</p> <p>Findings include:</p>	F 0314	It is the intent of our facility to ensure that residents who enter the facility without pressures sores, unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores, receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. The facility respectfully requests an IDR of this citation as the intent of the regulation was met as there have been no acquired pressure areas in the facility for 11 of the	11/06/2015

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	<p>On 10/5/15 at 9:15 A.M., a review of the clinical record for Resident #4 was conducted. The record indicated the resident was admitted on 9/28/12. The resident's diagnoses included, but were not limited to: lack of coordination, dementia with behaviors, anxiety and cardiac pacemaker.</p> <p>An Activities of Daily Living (ADL's) care plan, dated 3/31/15 with review on 9/2/15, indicated the resident was at risk for developing complications related to: needing total assistance with bed mobility, transfer, dressing, eating, and toilet use. The interventions included but were not limited to: nursing staff to provide ADL care to ensure daily needs are met, turn/reposition and shift weight to enhance circulation. A care plan, dated 7/28/14 and reviewed on 9/2/15, indicated the resident was at risk for skin breakdown related to incontinence, immobility and requires extensive/total assist with toileting. The interventions included, but were not limited to: assist to reposition/shift weight to relieve pressure and provide incontinence care after incontinence episodes.</p> <p>An Annual Social Service Review, dated 8/17/15, indicated the resident needed 2 person assist with transfer, grooming and</p>		<p>past 12 months - the issue could be included under 282, not following the plan of care, but the intent of this regulation was met.1. Resident #4, #28 and #82 had head to toe skin assessments completed and no skin issues were identified. 2. 100% of residents have had a head to toe skin assessment completed. 3. Licensed Nurses and C.N.A's have been re-educated on the facility policy and procedure related to pressure ulcer prevention by SDC/ Designee. The protocol for repositioning is following Signature's Skin Management and Prevention Program. If a resident were to acquire an area, the IDT team would meet and determine what repositioning protocol is needed to be put in place based on the resident's needs and the location of the pressure area.4. PI tool has been developed to monitor pressure ulcer prevention to be completed by DON/designee weekly x 4 and will remain a standing agenda item, to be presented by the DON/ designee at the monthly QAPI committee meeting.</p>	

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	<p>ADL's.</p> <p>During an interview, on 10/5/15 at 9:47 A.M., RN (Registered Nurse) #11 indicated the Resident #4 propelled himself throughout the building, in his wheel chair.</p> <p>The following observations were made:</p> <ul style="list-style-type: none"> <li>-On 10/1/2015 at 8:59 A.M., Resident #4 was observed sitting in wheelchair leaning to the right, asleep.</li> <li>-On 10/01/2015 at 10:00 A.M., the resident was observed in wheelchair, leaning to the right, facing the window, asleep, in the lounge area.</li> <li>-On 10/1/15 at 11:15 A.M., the resident was observed to be asleep, sitting in wheelchair, on the North hallway.</li> <li>-On 10/1/15 at 1:25 P.M., the resident was observed to be sitting in his wheelchair in the lounge area, looking out the window.</li> <li>-On 10/5/15 at 9:00 A.M., Resident #4 was observed sitting in the lounge area in in a padded wheel chair, a wanderguard was attached to right ankle. The resident was facing the hallway.</li> <li>-On 10/5/15 at 9:44 A.M., the resident propelled himself, in a wheel chair, to the doorway of lounge area.</li> <li>-On 10/5/15 at 11:19 A.M., the resident was observed in the same door way, except he was facing toward the lounge</li> </ul>			

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	<p>area.</p> <p>-On 10/5/15 at 11:47 A.M., the resident was assist to the dining room, in his wheel chair.</p> <p>-On 10/5/15 at 12:53 P.M., the resident was observed in his room getting his brief changed by CNA (Certified Nursing Assistant) #12 and CNA #13. The resident's brief was removed. CNA #13 indicated the resident's brief was saturated with urine. The resident was transferred to and off of the bed with a Hoyer device. Both CNA's indicated they had not checked or changed the resident's brief until "just now."</p> <p>-On 10/5/15 at 1:15 P.M. thru 4:15 P.M., the resident was observed propelling himself, in his wheelchair, up and down the hallway.</p> <p>-On 10/6/15 at 10:00 A.M., the resident was observed coming from the shower room.</p> <p>-On 10/6/15 at 10:15 A.M., the resident was observed sitting in his wheel chair, in front of the nurse's station.</p> <p>-On 10/6/15 at 10:45 A.M., the resident was observed on another unit propelling himself in a wheel chair.</p> <p>2. On 10/6/15 at 10:00 A.M., a review of the clinical record for Resident #28 was conducted. The record indicated the resident was admitted on 6/16/15. The resident's diagnoses included, but were</p>			

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	<p>not limited to: dementia with out behavior disturbance, atrial fibrillation, hypertension, renal failure and depressive disorder.</p> <p>A 60 day MDS (Minimum Data Set) Assessment, dated 8/11/15, indicated the resident was an extensive assist of 2 persons with bed mobility, transfers and toilet use. The assessment indicated the resident was at risk for a pressure ulcer.</p> <p>The At Risk for Pressure Ulcers care plan, dated 9/8/15, indicated the resident was at risk for a pressure ulcer due to immobility, incontinence. Interventions included but were not limited to: assist to reposition/shift weight to relieve pressure as needed, provide incontinence care after incontinence episodes, and provide pressure relieving chair cushion.</p> <p>The following observations were made: -On 10/1/15 9:25 A.M. thru 11:15 A.M., the resident was sitting in wheelchair in her room or on the unit -On 10/5/15 at 9:03 A.M. thru 11:50 A.M. resident was observed sitting in a padded wheel chair, on the unit. The resident was propelled to the dining room in her wheel chair and was placed in front of a table. -On 10/5/15 at 12:53 P.M., CNA #14 and LPN #15 was observed taking the</p>			

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	<p>resident, from the dining room, into the restroom, in her wheel chair. The resident was assist onto the toilet and a heavy/saturated brief was removed. CNA #14 indicated she had not changed the resident's brief earlier.</p> <p>-On 10/6/15 at 10:10 A.M., resident was observed in the lounge area until lunch time.</p> <p>On 10/7/15 at 11:44 A.M., the resident's buttock/coccyx area was observed with CNA #14 and QMA (Qualified Medication Aide) #16. The resident's skin was reddened with large ridges from the brief, the resident's skin was intact.</p> <p>3. On 10/6/15 at 9:10 A.M., a review of the clinical record for Resident #82 was conducted. The record indicated the resident was admitted on 9/28/15. The resident's diagnoses included, but were not limited:urinary tract infection, dementia with behavioral disturbance, depressive disorder, glaucoma and neurogenic bladder.</p> <p>A MDS admission/ 5 day assessment, dated 10/5/15, indicated the resident required extensive assist of 2 persons with transfers and used a wheel chair as a mobility device. The assessment indicated the resident was at risk for a pressure ulcer determines by an</p>			

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	<p>assessment tool (Braden).</p> <p>A Care plan for ADL's, dated 10/7/15, indicated the resident needed assistance due to dementia and generalized weakness. The interventions included but were not limited to: turn and reposition the resident as needed to enhance circulation and for comfort.</p> <p>The following observations were made:                      -On 10/5/15 at 9:03 A.M., Resident #82 was observed sitting in a wheel chair in the hallway.                      -On 10/5/15 at 9:06 A.M., the resident was propelled into the lounge area via his wheelchair and remained there until 10:33 A.M.                      -On 10/5/15 at 10:33 A.M., the resident was taken to his room by the Social Service Director to conduct an interview for MDS assessment. The resident was brought back to lounge area at 10:37 A.M. and was positioned in front of the TV.                      -On 10/5/15 from 10:37 A.M. until 11:32 A.M., the resident was observed sitting in his wheel chair in the lounge area with eyes closed.                      -On 10/5/15 at 11:32 A.M., the resident was observed propelling himself down the hallway. At 11:34 A.M., the resident was observed being propelled by a staff member to dining room, in his wheel</p>			

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	<p>chair. At 11:50 A.M., meal service started.</p> <p>-On 10/5/15 at 1:31 P.M., the resident's was observed sitting in the dining area with his wife. The resident was taken to his room to have the catheter emptied by the CNA. CNA #14 did not assist the resident to a standing position or reposition the resident after emptying the resident's catheter. The wife returned the resident to the lounge area and resident remained in his wheel chair with his feet up on a chair until 3:15 P.M.</p> <p>On 10/7/15 at 1:30 P.M., the Director of Nursing (DON) provided a policy titled " Repositioning," dated April 2013 and indicated the policy was the one currently used by the facility. The policy indicated "...General Guidelines 1. Repositioning is a common, effective intervention for preventing skin breakdown, promoting circulation, and providing pressure relief...3. Repositioning is critical for a resident who is immobile or dependant upon staff for repositioning...."</p> <p>3.1-40(a)</p>			

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F 0315 SS=D Bldg. 00	<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 review and interviews, the facility failed to thoroughly assess the bladder incontinence and provide interventions to restore as much normal bladder function as possible for 2 of 3 residents reviewed for incontinence. (Resident #45 and 59)</p> <p>Findings include:</p> <p>1. On 10/01/15 at 2:21 P.M., Resident #45 was observed seated in his recliner in his room. His wheelchair was located in front of his recliner. The resident's room, especially around where he was seated smelled strongly of urine.</p> <p>The clinical record for Resident #45 was reviewed on 10/05/2015 at 9:02 A.M.</p>	F 0315	<p>It is the intent of the facility to thoroughly assess the bladder function and provide interventions to restore as much normal bladder function as possible for all residents. 1. Residents #45 and #59 were re-assessed and care plan and C.N.A care cards updated to reflect current status. 2. 100% Audit has been completed to ensure the resident's current bladder status is reflected on their plan of care and C.N.A care card. 3. Licensed nursing staff, C.N.A's and IDT have been re-educated by the SDC/ designee on the facility policy and procedure related to meeting resident incontinent needs, ensuring that plan of care and C.N.A. care cards reflect resident's needs. 4. PI tool has</p>	11/06/2015

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	<p>Resident #45 was admitted to the facility on 01/16/14 with diagnoses, including but not limited to: advanced dementia, history of urinary tract infection, history of falls, atrial fibrillation, bradycardia, hypertension, benign prostatic hypertrophy and long term anticoagulation.</p> <p>The current medication orders for Resident #45 included the medication, Tamsulosin HCL (hydrochloride) for urinary retention issues.</p> <p>An admission nursing assessment, Bladder Status Screening assessment, completed on 01/16/14, indicated the resident had no apparent pattern, voided every 2 - 3 hours, was occasionally incontinent, and wore briefs.</p> <p>A Bladder Status Evaluation, completed on 05/08/14, indicated the resident had been incontinent for approximately 2 to 2 1/2 months, used a urinal at night but was "spilling it and sometimes doesn't get to urinal in time." The assessment indicated the resident did not wear a brief but "should..." The resident was assessed with functional incontinence due to poor mobility, arthritis, and dementia. There was no type of toileting program chosen for Resident #45 at the bottom of the form.</p>		<p>been developed to monitor the resident's incontinent status and care plan implementation and C.N.A care card updates. Monitoring to be done by the DON/designee weekly x 4 and then monthly x 3 and reported by the DON to the monthly QAPI team, until such time as the committee feels that substantial compliance has been achieved.</p>	

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	<p>A care plan related to ADLs (activities of daily living) , initiated on 01/13/15 and reviewed as current on 07/08/15, indicated the resident required assist of one for toilet use. The intervention indicated "provide only the amount of assistance/supervision that is needed at the time of care" and "Resident requests urinal and refuses to use bathroom. Frequently spills urinal on self, furniture, bedding but does not notify staff."</p> <p>A current care plan regarding potential for complications associated with urinary incontinence indicated the resident was frequently incontinent and included the following interventions: "provide/encourage use of adaptive equipment urinal, monitor need/schedule appropriate diagnostic procedure prn, report any change in bladder status to nurse, report change is bladder status to physician prn, monitor labs as ordered and report results to physician, check resident for incontinent episodes, provide peri care after each incontinent episode, encourage resident to get out of bed to bathroom but give urinal if asks"</p> <p>On 10/05/2015 at 8:45 A.M., Resident #45 was not observed in his room. The room smelled of urine. There was a croquet afghan located on the seat of his</p>			

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	<p>recliner. A housekeeper was noted to be wiping the hard surfaces in his room with a yellow colored spray.</p> <p>On 10/05/2015 at 9:01 A.M., Resident #45 was noted to be seated in his recliner in his room with his wheelchair in front of the recliner At 9:35 A.M., he was noted to be standing in front of his recliner, his brief was still in place and he was struggling to pull up his outside pant. CNA (Certified Nursing Assistant) #52 was alerted and by the time she arrived in his room, Resident #45 was seated on the end of his recliner and his outside pants were not pulled up to his waist. He requested help getting his pants pulled up properly. CNA #52 assisted him to pull up his pants and seated him back in the recliner with his feet elevated. She indicated he did not seem to have to use the restroom but she did not ask him if he needed any assistance with toileting. She indicated the pants he was wearing were too loose around the waist and must have fallen down when he stood up. She indicated she did not assist Resident #45 with his toileting as he used a urinal by himself.</p> <p>Resident #45 remained in his room sleeping in the recliner until 11:53 A.M. when he was noted to have transferred to</p>			

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	<p>the wheelchair and taken himself into the dining room. A small amount of urine was noted in the urinal in his room and the room smelled strongly of urine.</p> <p>On 10/06/2015 at 8:42 A.M., Resident #45 was observed to propel his wheelchair into his room, he stood up, unfastened his outside pants, which exposed a brief, transferred self to recliner, put his feet up on recliner and pulled a blanket over himself. A few minutes later, he put the foot rest down on the recliner and stated he was going to use the urinal. An empty urinal was noted on the overbed table. The Maintenance Supervisor was noted in Resident #45's bathroom replacing the bathroom flooring. The resident door was shut so he would have privacy to use the urinal.</p> <p>On 10/06/2015 8:48 A.M., Resident #45 was noted to be covered up lying in his recliner. The urinal was empty. Interview with the Maintenance Supervisor who was still in the adjoining bathroom indicated he did not think the resident remembered what he was doing, did not actually use the urinal but just sat back down into the recliner. The Maintenance Supervisor indicated he thought he resident did not always follow through due to his dementia. Resident</p>			

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	<p>#45 remained in his recliner asleep from 8:48 A.M. to 11:17 A.M., with an empty urinal setting on the overbed table. At 11:28 A.M., a small amount of urine was noted in the urinal which was on the overbed table and the resident and his wheelchair were not in the room. The Maintenance Supervisor, who was in the resident's bathroom now replacing the toilet, indicated he was not aware of where the resident had gone. The room still smelled strongly of urine and the resident's recliner seat, which had a croqueted afghan on the seat was touched and noted to be damp. The Maintenance Supervisor indicated he knew that room smelled of urine and indicated he would take care of the resident's wet recliner.</p> <p>At 10/06/15 at 11:57 A.M., therapist #53 was noted pushing Resident #45 back into his room. Therapist #53 indicated he had assisted Resident #45 with using the urinal before he was taken to the therapy room. The Maintenance Supervisor informed Resident #45 that his recliner had been "cleaned" and his croqueted afghan was noted in a plastic bag.</p> <p>During an interview with CNA #54, on 10/07/15 at 2:16 P.M., she indicated she did not toilet or assist Resident #45 with toileting needs and he was able to utilize the restroom by himself.</p>			

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	<p>A nursing assistant assignment sheet for the South unit, dated 10/02/15, indicated Resident #45 was identified as incontinent and wore extra large pull ups. "Cue resident to use bathroom" was also documented on the instruction sheet.</p> <p>2. The clinical record for Resident #59 was reviewed on 10/5/15 at 9:37 A.M. Resident #59 was admitted to the facility, on 3/14/14, with diagnoses, including but not limited to: Parkinson's disease, paralysis, senile dementia, joint contracture of the hand and forearm and depressive disorder.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 8/12/15, indicated the resident scored a 4 out of 15 on the BIMS (Brief Interview for Mental Status), required total dependence of staff for transfers and extensive 2 plus staff assist for toilet use. The resident was documented as always incontinent of his bladder.</p> <p>A nursing admission assessment, completed on 3/14/14, indicated the resident was always incontinent and physically reliant on a caregiver to go to the bathroom. The assessment indicated</p>			

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	<p>the resident wore a brief for protection and was not able to participate in a toileting program.</p> <p>A care plan, dated 3/23/15 and revised on 8/2/15, indicated the resident was at risk for an active behavior problem related to a history of being physically abusive, resisting care and is uncooperative. The interventions included, but were not limited to: anticipate care needs and provide them before the resident becomes overly stressed, explain care to resident in advance in terms resident understands, monitor behavior episodes and attempt to determine the underlying cause and reproach the resident later when he becomes agitated.</p> <p>A care plan, dated 7/17/15 and revised on 8/10/15, indicated the resident was at risk for potential complications associated with urinary incontinence related to impaired mobility and impaired cognitive status. The interventions included, but were not limited to: report any changes in bladder status to the physician and the nurse, check the resident for incontinent episodes and provide peri care after each incontinent episode.</p> <p>On 10/1/15 from 9:00 A.M. to 10:29 A.M., Resident #59 was observed seated in his wheelchair watching television in</p>			

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	<p>the resident lounge, the resident has a contracture of the left hand and fingers. He was dressed and had a lap blanket draped over his lower extremities. There was a strong urine odor around the resident. The resident remained in the same position and was not checked or changed during this time. At 10:30 A.M., the resident was taken in his wheelchair from the resident lounge to the activity room for the morning activity. The resident remained in the activity room until 11:38 A.M. At 11:39 A.M., the resident was taken to the dining room across the hallway. The resident was not observed to be checked or changed during this time frame.</p> <p>On 10/5/15 from 9:15 A. M. to 11:50 A.M., Resident #59 was observed seated in his wheelchair in his room in front of the television. The resident was awake and alert, he was dressed and had a lap blanket draped over his lower extremities. The resident was not observed to be checked or changed during this time. At 11:51 A.M., the resident was taken directly from his room down to the dining room by CNA # 1. At 1:15 P.M., the resident was observed seated in his wheelchair in the resident lounge, CNA #1 assisted the resident back to his room. The resident was then transferred into his bed with the assist of</p>			

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	<p>2 CNA's and the use of a Hoyer lift (a mechanical lift). The pressure relieving cushion in the residents wheelchair was wet. CNA #1 removed the residents light colored cotton pants that were heavily saturated with strong smelling urine. The residents brief was removed and it was heavily saturated with urine. An interview at that time with CNA #1 indicated "...well you know why he is so wet don't you? It is because he refused to lay down at 10:00 this morning. He refuses care frequently and when he says no he means no, he can also be combative with care. I mean what am I suppose to do if he refuses he has the right to refuse care...." CNA #1 further indicated if the resident refused care she would go back and check on him later.</p> <p>During an interview, on 10/5/15 at 1:21 P.M., CNA #2 indicated the resident was to be checked and changed before and after meals and as needed. CNA #2 further indicated the resident is always incontinent and is not able to tell staff when he needs to go.</p> <p>A behavior/intervention monthly flow record, dated October 1st-5th 2015, indicated behavior #1: combative with care, there was no documentation of the resident being combative with care for the day, evening or night shift. Behavior</p>			

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F 0318 SS=D Bldg. 00	<p># 3: refusing meals, care and meds, there was no documentation of the resident refusing care on day, evening or night shift from October 1st-5th 2015.</p> <p>An incontinence report, dated 10/5/15, indicated Resident #59 had 2 incontinent episodes on the day shift at 1:53 P.M.</p> <p>During an interview, on 10/6/15 at 2:10 P.M., the MDS Coordinator indicated the CNA's enter information into the kiosk (a computer program) regarding incontinence care, unfortunately there is no way for the staff to differentiate at what time the resident had an incontinent episode, the report just shows how many times in one shift the resident was incontinent. She further indicated the nursing staff do not complete a separate bladder assessment anymore and that her information regarding incontinence comes from the incontinence report that the CNA's fill in.</p> <p>3.1-41(a)(2)</p> <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a</p>			

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	<p>resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interviews, the facility failed to provide preventative range of motion and interventions for a resident with a contracture of the left hand and fingers for 1 of 3 residents reviewed for range of motion. (Resident #59)</p> <p>Findings include:</p> <p>The clinical record for Resident #59 was reviewed on 10/5/15 at 9:37 A.M. Resident #59 was admitted to the facility, on 3/14/14, with diagnoses, including but not limited to: Parkinson's disease, paralysis, senile dementia, joint contracture of the hand and forearm and depressive disorder.</p> <p>The quarterly MDS (Minimum Data Set) assessment, completed on 8/12/15, indicated the resident scored a 4 out of 15 on the BIMS (Brief Interview for Mental Status), required extensive 2 person assist with bed mobility, dressing and personal hygiene and extensive 1 person assist with eating.</p> <p>A physician order, dated 5/27/14, indicated left upper extremity splint required to reduce further development of</p>	F 0318	<p>It is the intent of this facility to ensure that every resident with a limited range of motion (ROM) receives appropriate treatment and social services to increase range of motion and/or prevent further decrease in ROM. The facility respectfully requests an IDR of this tag as the resident's contracture management has been addressed, well documented, and in adherence with the resident's right to refuse. There is no indication of further decrease in ROM nor is there any indication of skin breakdown as staff perform daily PROM while providing morning care to the hand. No other residents were identified with ROM concerns not being addressed and/or monitored appropriately by staff.</p> <p>1. Resident # 59 is has been referred back to Occupational Therapy. 2. Resident's with splints and/ or contracture devices have been reviewed to ensure ROM plan is in place, care plan / care guides reflect current status. 3. Licensed Nursing staff and C.N.A.'s have been re-educated with SDC/ designee related to ROM and contracture management. 4. PI tool has been developed to monitor ROM to be completed by DON/designee weekly x 4 and monthly x 3 and</p>	11/06/2015

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	<p>a contracture.</p> <p>An Occupational Therapy evaluation, dated 4/14/15, indicated the reason for the referral was due to a decline in self feeding skills, an increased need for assistance from others and a decrease in strength indicating the need for OT (Occupational Therapy) to assess the need for adaptations and to maximize rehab potential. The resident has not been using his splint and appears to behaving more contracted joints to the left forearm. Impression: Patient has not been using the splint for his left forearm and is in the process of developing a fixed contracture. Due to the documented physical impairments and associated functional deficits, the patient is at risk for behavioral outbursts, contracture(s), decreased participation with functional tasks, decreased skin integrity, increased agitation and increased tone, limiting functional movement.</p> <p>An Occupational Therapy discharge summary, dated 5/13/15, indicated the patient refuses the splint to the left hand, but is compliant with the carrot orthosis. Patient is easily agitated when receiving interventions, but if everything is explained well, then the patient tolerates well. Discharge recommendations: patient is to have the carrot orthosis in</p>		<p>will be reviewed in the QAPI meeting by the DON/designee quarterly thereafter until such time as QAPI committee determines substantial compliance was achieved.</p>	

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	<p>the left hand except when engaged in activities. PROM (passive range of motion) needs to be performed to the BUE (bilateral upper extremity) to maintain current ROM (range of motion) to enable the patient to continue with self feeding and leisure tasks such as using the remote control.</p> <p>A Rehab Communication Slip, dated 5/29/15, indicated the type of change/recommendation: 1. the splint for the L (left) hand has been dc'd (discontinued) d/t (due to) pt (patient) refusal to tolerate. 2. Patient is to have an ortho carrot in the L hand. To be removed for meals, hygiene etc. Persons notified: Nursing.</p> <p>A care plan, dated 5/28/14 and revised on 8/13/15, indicated the resident had increased tone to the left hand/wrist which places (resident name) at risk for contractures. Interventions included, but were not limited to: Occupational therapy as ordered. Observe the skin when applying or removing splints. Report red, rashy, irritated or open areas to the nurse. Apply splints as ordered. Observe for s/sx (signs or symptoms) of pain such as grimacing, moaning, and fidgeting with splints. Observe for changes in functional use or ROM to hand/arm and notify the nurse. Keep MD (Medical Doctor)</p>			

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	<p>informed.</p> <p>A care plan, dated 3/23/15 and revised on 8/2/15, indicated the resident was at risk for active behavior problems related to history of being physically abusive, history of being verbally abusive, resisting care, uncooperative and is combative with caregivers. Interventions included, but were not limited to: Anticipate care needs and provide them before the resident becomes overly stressed. Explain care to the resident in advance, in terms the resident understands. Monitor behavior episodes and attempt to determine the underlying cause. Reapproach the resident later, when he becomes agitated.</p> <p>A Request for Therapy Evaluation form, dated 10/1/15, indicated from a nursing assessment the resident has had a recent change in the ability to tolerate the carrot as evidenced by: refusing to wear the carrot on LUE (left upper extremity). OT (Occupational Therapy) to d/c carrot to LUE. Nursing to complete PROM to UE (upper extremity).</p> <p>A behavior/intervention monthly flow record, dated October 1st-5th 2015, indicated behavior #1: combative with care, there was no documentation of the resident being combative with care for</p>			

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	<p>the day, evening or night shift. Behavior # 3: refusing meals, care and meds, there was no documentation of the resident refusing care on day, evening or night shift from October 1st-5th 2015.</p> <p>On 10/1/15 at 10:19 A.M., Resident #59 was seated in his wheelchair in the resident lounge. The resident had a lap blanket draped across his lower extremities. His left hand and fingers are contracted, no splint or carrot orthotic was observed.</p> <p>On 10/5/15 at 10:33 A.M., Resident #59 was observed seated in his wheelchair in his room watching the television. His left hand and fingers are contracted and no splint or carrot orthotic was observed in his hand.</p> <p>On 10/6/15 at 9:10 A.M., Resident #59 was assisted back to bed by CNA (Certified Nursing Assistant) #1 and CNA #2 and the use of a Hoyer lift (a mechanical lift). CNA #1 indicated to the resident she wanted to open his fingers on his left hand to look at the palm of his hand, as CNA #1 attempted to bend the residents fingers out straight the resident grimaced as if in pain and attempted to hit CNA#1 with is right hand. No open areas were observed on the palm of the residents left hand. During an interview</p>			

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	<p>at that time with CNA#1 she indicated the resident refuses to wear the carrot orthotic because it is uncomfortable and he becomes combative at times with care. She further indicated she performed ROM on the residents left hand and fingers when she gave him a shower this morning.</p> <p>During an interview, on 10/6/15 at 9:55 A.M., the DON (Director of Nursing) indicated the resident refuses to wear the carrot orthotic anymore so it was discontinued on 10/1/15. She further indicated listed on the resident care sheet under the special needs section for this resident there are instructions for the CNA's to wash and dry the residents hand every shift. The DON indicated the expectation would be that the staff would do PROM to the hand and fingers when they wash the hand. The DON indicated there was no specific place for the staff to document when PROM has been completed.</p> <p>During an interview, on 10/6/15 at 10:41 A.M., the Occupational Therapist, Employee #3, indicated she was not made aware the resident was refusing to use the carrot orthotic in his left hand until 10/1/15 when a staff nurse informed her that "he just won't wear it and flat out refuses it and will swing at staff when</p>			

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	<p>they try to apply the carrot orthotic". She further indicated she had not worked with the resident since his discharge in May of 2015 and at that time he was using the carrot orthotic. She indicated as long as staff approach him in a calm manner and explain things prior to doing it he will allow you to work with his hand. Employee #3 indicated she will re-evaluate the resident today and see if further therapy will benefit him.</p> <p>On 10/7/15 at 2:00 P.M., the DON provided a policy titled "Care Planning," dated February 2014, and indicated the policy was the one currently used by the facility. The policy indicated "...3. Each resident's comprehensive plan is designed to:...g. aid in preventing or reducing declines in the resident's functional status and/or functional levels...5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers...8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change...9. The care planning/ Interdisciplinary Team is responsible for the review and updating of the care plans:</p>			

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F 0323 SS=G Bldg. 00	<p>a. When there has ben a significant change in the resident's condition. b. When the desired outcome is not met...d. At least quarterly...."</p> <p>3.1-42(a)(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, record review and interview, the facility failed to ensure there was adequate supervision prevent a fall with injury for 1 resident reviewed for accidents in a sample of 1. This occurred when Resident #65 assisted Resident #33 to the bathroom. Resident #33 fell and sustained a Fractured Right Femur. In addition, the facility failed to ensure the handrails on 3 of nursing units were free from splintered areas and 1 of 3 halls was free from accessible chemicals.</p>	F 0323	<p>It is the intent of this facility to ensure the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance to prevent accidents. 1. Resident #33 no longer resides at this facility. Resident #65 care plan and C.N.A care card has been reviewed and updated. The disinfectant wipes found in room 216 were immediately removed. The areas indicated as being rough on the handrails were</p>	11/06/2015

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	<p>Finding includes:</p> <p>1. The clinical record for Resident #33 was reviewed on 10/07/2015 at 3:07 P.M. Resident #33 was admitted to the facility, on 01/11/14, with diagnoses, including but not limited to: Alzheimer's dementia, osteoarthritis and muscle weakness.</p> <p>A reportable fall investigation, completed on 08/14/15 indicated on 08/13/15 at 5:17 P.M., Resident #33 was found on the floor. The incident report and investigation indicated Resident #65 had turned off the wheelchair alarms and unfastened a seatbelt for Resident #33 and had attempted to assist Resident #33 to transfer to the toilet. Resident #65 had then alerted CNA (Certified Nursing Assistant) #57 when Resident #33 had ended up falling to the floor. Both residents resided on the secured dementia unit at the time of Resident #33's fall. Resident #33 was transferred to an acute care facility and diagnosed with a Fractured Right Femur.</p> <p>The nursing progress notes for Resident #65 on July 16, 23 and 31, 2015, indicated the resident had been observed attempting to help other resident's to the bathroom or to bed and had to be redirected. Resident #65 would become</p>		<p>sanded the same day. 2. Care plans for residents on the Serenity unit were reviewed/revised to include behaviors that could lead to a potential hazard/accident. The environmental supervisor made rounds in all resident rooms to ensure no other outside chemical cleaning products were present in any resident rooms. All handrails were checked to ensure no other rough or jagged edges were present. 3. All facility staff have been re-educated regarding the prevention of accident's and hazards by the SDC/ designee. 4. PI tool has been developed that will monitor compliance with resident's safety, unsecured chemicals/ hazards to include handrails and chemical wipes and will be completed by the Maintenance director/DON/designee weekly x 4 and monthly x 3 and reviewed by the DON and The Maintenance Director and/ or their designees at the monthly QAPI committee meeting until such time as substantial compliance has been achieved.</p>		

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	<p>very upset when redirected from that activity.</p> <p>The behavior tracking for Resident #65 for August and September 2015 indicated the resident was being monitored for delusions, yelling at other, pacing, and tearfulness. There was no care plan intimated specific to the resident's behavior of attempting to assist other residents with transferring and toileting needs.</p> <p>Observation of the secured dementia unit, on 10/07/15 at 5:00 P.M., indicated the unit was u-shaped with a kitchenette and television area on end of the u-shape, a dining room at the end, and the resident rooms and hallway on the other end of the u-shape.</p> <p>Resident #65 was observed seated in a chair beside her bed awake. She later was observed to ambulate independently out of her room and seat herself on the couch.</p> <p>During an interview, on 10/07/2015 at 3:15 P.M., CNA #57 indicated on the evening of 08/13/15 he was the only staff member working on the dementia unit. He indicated he was around the corner by the kitchenette at the sink, washing his hands, when Resident #65 came to get</p>			

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	<p>him to let him know that Resident #33 had fallen. He indicated when he was working by himself and needed to help individual residents or was at the sink, he could not possible supervise the other residents. CNA #57 confirmed Resident #65 then told him she had been attempting to help Resident #33 and had turned off the alarms. He indicated the normal staffing for the dementia unit was 2 staff but sometimes there was only 1 staff member scheduled.</p> <p>2. On 10/1/2015 at 9:14 a.m., a container of disinfectant wipes was observed by the TV in room 216.</p> <p>During a tour of the facility on 10/5/2015 from 9:10 a.m. to 10:12 a.m. accompanied by the Maintenance Supervisor, the following was observed:</p> <p>The handrails located on the North Unit, Serenity Unit, and the South Unit, had rough and jagged areas.</p> <p>There was a bottle of antibacterial wipes sitting on a nightstand in room 216.</p> <p>During an environmental tour on 10/5/2015 at 2:37 p.m., the Maintenance Director indicated that he had identified the handrails had rough areas and indicated that the antibacterial wipes</p>			

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F 0328 SS=D Bldg. 00	<p>located on the nightstand in room 216 were not supposed to be there.</p> <p>On 10/7/2015 at 11:32 a.m., the Maintenance Director provided a policy titled, "Accident Prevention," dated 01/2005, and indicated that policy was the one currently used by the facility. The policy indicated "...8. Keep all bottles out of residents' reach and have bottles labeled. Keep janitorial closets locked at all times. Do not spray any cleaning chemical in the direction of a resident...".</p> <p>On 10/7/2015 at 11:32 a.m., a form titled, "LOGBOOK DOCUMENTATION," provided by the Maintenance Director, indicated that the handrails had been checked on September 11, 2015 by the Maintenance Director.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents</p>			

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	<p>receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, record review and interviews, the facility failed to ensure foot care was provided for 1 of 3 dependent residents reviewed for skin issues. (Resident #27)</p> <p>Finding includes:</p> <p>The clinical record for Resident #27 was reviewed on 10/05/2015 at 11:26 A.M. Resident #27 was admitted to the facility on 02/02/15 with diagnoses, including but not limited to: hypertension, hypothyroidism, congestive heart failure, pain, Alzheimer's dementia, depression, venous insufficiency with edema, osteoarthritis and muscle weakness.</p> <p>Physician progress notes indicated the resident has an infected skin rash with cellulites to her right lower extremity in September 2015.</p> <p>A quarterly MDS assessment, completed on 09/14/15, indicated the resident scored a 9 of 15 on a BIMS assessment (Brief</p>	F 0328	<p>It is the intent of this facility to ensure that residents receive proper treatment and care for the following special services: Injections, Parenteral and enteral fluids, colostomy, ureterostomy and/ or ileostomy care; tracheostomy care; tracheal suctioning; respiratory care, foot care and prosthesis. 1. Resident #27 received foot care and lotion applied. 2. All resident have had Foot assessments completed and care plans/ care cards have been updated to reflect current status. 3. Licensed Nursing staff and C.N.A's have been re-educated regarding resident foot care. 4. PI tool has been developed that will monitor compliance with resident foot care to be completed by DON/designee weekly x4, monthly x 3 and will be reviewed by the DON/ designee in the QAPI committee meeting until such time as substantial compliance has been achieved.</p>	11/06/2015

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	<p>Interview for Mental Status), moderately cognitively impaired. The resident required extensive staff assistance of two staff for personal hygiene and was dependent on staff for bathing needs.</p> <p>Resident #27 was observed to spend all of her time, on 10/02/15, 10/05/15 and 10/06/15 lying in her bed, on her back on a regular mattress. She had foot cradle which often was misplaced under her knees instead of under her shins. She was noted to be dressed all three days in a gown and gripper socks that fit tight around the bottom of her ankles.</p> <p>On 10/06/2015 at 9:08 A.M., LPN (Licensed Practical Nurse) #51 was in Resident #27's room. Resident in bed sitting up awake in hospital gown. LPN #51 indicated she had just changed the dressing on the resident's leg. Observation of the resident's legs and feet indicated a dressing was noted on the resident's right shin area. The nurse indicated there were some weeping and bleeding areas on her leg. The resident's feet had nonslip socks on them and the resident's heels were pushing against the mattress. There was a foot cradle but it was pushed up around the resident's knees and was not floating her heels. The nurse did not reposition the foot cradle.</p>			

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	<p>Resident #27's feet were observed on 10/06/15 at 1:35 P.M. with CNA s #55 and 58. The resident's socks were removed per request and her feet were noted to be extremely dry and scaly with lots of loose skin flakes falling on the bed when the sock was removed.</p> <p>Resident #27's legs and feet were observed on 10/07/2015 at 10:21 A.M. with RN (Registered Nurse) #59. The resident's right foot was swollen, her feet were very dry with scaling skin and the skin between her toes was not visible due to a build up between her toes. The inside of her toes were reddened but not open. There was a large dark green dried chunk of "toe jam" described by RN #59 as looking like a "booger" between the 4 and 5 toe on her left foot.</p> <p>The electronic documentation for Resident #27 for October 2015 was reviewed and she was documented as having received a shower on 10/06/15 at 11:57 A.M.</p> <p>During an interview on 10/07/15 at 11:00 A.M., CNA #55 indicated she and CNA #58 had given Resident #27 a bed bath on 10/06/15. CNA #55 could not remember when the bed bath had been given, did not know why a shower had been</p>			

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	<p>documented and indicated CNA #58 must have documented the bed bath incorrectly. When informed a shower had been documented on 10/06/15 at 11:57 A.M. and had not been observed to have been completed, CNA #55 indicated she could not remember when the bed bath had actually been completed.</p> <p>The most recent podiatry examination, completed for Resident #27 on 07/30/15, indicated the resident had absent hair growth on both feet, decreased elasticity on both feet, decreased skin turgor on both feet and dry skin on both feet. The recommendations were for lotion to be applied to her feet after her showers.</p> <p>During an interview on 10/07/15 at 11:30 A.M., the Director of Nursing indicated lotion to feet would not necessarily be documented as it was considered a standard of practice to lotion skin after bathing a resident.</p> <p>3.1-47(a)(7)</p>			

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F 0329 SS=D Bldg. 00	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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> <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 record review and interview the facility failed to ensure 1 of 5 residents reviewed for unnecessary medications had adequate indications for the use of an antianxiety medication and an antipsychotic medication. (Resident #28)</p> <p>Finding includes:</p> <p>On 10/6/15 at 10:00 A.M., a review of the clinical record for Resident #28 was</p>	F 0329	It is the intent of this facility to ensure that each resident is free of unnecessary drugs. The facility respectfully requests an IDR of this citation because there is documentation to show the resident had the diagnoses to support the usage/need of the medication and there is documentation on the behavior log to support the continued need for the medication.1. Resident #28 has been re-evaluated by geriatric psychiatric nurse	11/06/2015

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	<p>conducted. The record indicated the resident was admitted on 6/16/15. The resident's diagnoses included, but were not limited : dementia without behavior disturbance, atrial fibrillation (a-fib), hypertension, Alzheimer with behaviors, renal failure and depressive disorder.</p> <p>The October 2015 Medication Administration Record (MAR) indicated the resident's medications included but were not limited to: lorazepam 0.25 mg (milligrams) daily for anxiety and zyprexa 10 mg at every night for delusions.</p> <p>A Behavior/Intervention Monthly Flow Record was reviewed for July, August September and November of 2015. The resident had no documented behaviors of delusions or anxiety in July, August, September and October to date.</p> <p>A pharmacy recommendation, dated 7/1/6/15, for a gradual reduction of zyprexa (antipsychotic medication) was received and an order was written to reduce zyprexa from 10 mg daily to 5 mg daily.</p> <p>A Social Service Progress Note, dated 7/30/15, indicated "...Reviewed in beh [behavioral] management - GDR [gradual dose reduction] done 7/16 on zyprexa -</p>		<p>practitioner and behavior monitoring sheet has been reviewed/ revised to reflect the specific use of the anxiolytic. Resident #28 care plan and C.N.A care card have been reviewed and updated to reflect current status. The behaviors identified and being monitored are in fact, symptoms of anxiety displayed behaviors in patients with dementia. 2. All residents on psychotropic medications have been reviewed to ensure that all medications are included on the behavior management care plan to include type of medication and potential side effects. 3. IDT team will be educated by SCC related to Behavior Monitoring Tool, medications and medication side effects. 4. PI tool has been developed to monitor all psychoactive medications and/ or side effects on resident behavior management plan to be completed by SS/DON/designee weekly x 4 and monthly x 3 and will be reviewed by DON/ SS and or designee in the QAPI committee meeting until such time as substantial compliance has been achieved.</p>	

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	<p>displayed increased behaviors -see NN [nursing note] 7/29/15, 7/30, 7/27. addressing readjusting zyprexa back to 10 mg with MD. Order recvd [received] to be seen by [name of local psychiatric NP]...."</p> <p>A form titled "Daily Skilled Nurse's Note, dated 7/27/15 indicated the resident had no behaviors documented. Another Nurse's Note, dated 7/29/15 was cursing at other residents, threw silver ware, and hit nurse, intervention was to stay with the resident until the routine Ativan became effective. A Nurse's Note, dated 7/30/15, indicated the resident "spit out afternoon meds"</p> <p>Physician's order, dated 8/4/15, indicated to discontinue the zyprexa 5 mg daily and start zyprexa 10 mg daily.</p> <p>A 60 day Minimum Data Set (MDS) Assessment, dated 8/11/15, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 6; severe cognitive impairment. The Behavior Section indicated no hallucinations or delusions. The Assessment further indicated the resident had not exhibited any behaviors such as physical/verbal behaviors, rejection of care or wandering.</p> <p>The At Risk for Behaviors care plan,</p>			

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	<p>dated 6/19/15 and reviewed on 9/6/15, indicated resident was "physically abusive, socially inappropriate, verbally abusive and resisted care as evidenced by combative with care, refused meals, care, medication, yelling, screaming, swearing, delusions, throwing things and delusional-paranoid related to Alzheimer/dementia". The interventions included, but were not limited to: administer and monitor the effectiveness and side effects of medications ordered, invite and encourage activity programs consistent with resident's interests and reduce stressors such as noise/sudden changes.</p> <p>A care plan for Psychotropic Drug Use, dated 6/19/15 and reviewed on 9/10/15 indicated "...Drug class: anti-anxiety, anti-psychotic, anti-depressant...Diagnosis for which drug has bee prescribed: anxiety, senile psychosis/delusions, and anxiety...." The interventions include but were not limited to: administer medication as prescribed, monitor for effectiveness, and attempt dose reductions quarterly.</p> <p>During an interview, on 10/7/15 at 3:28 P.M., the Social Service Director (SSD)indicated the resident was on zyprexa since admission from psychiatric hospital with delusions and diagnosis of</p>			

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	<p>dementia with behaviors. The SSD indicated the resident had a delusion on 7/31/15 because the resident thought she was in a barn. The SSD was unsure of the interventions attempted prior to increasing the zyprexa dose. She further indicated the behavior log had no documentation of delusions in July or August. The SSD indicated the resident's anxiety was expressed by the behaviors of screaming, yelling, swearing, being combative with care, however the behavior monitoring flow record did not indicate the resident was taking the anti-anxiety medication lorazepam for those behaviors.</p> <p>On 10/7/15 at 5:30 P.M., the SS Director provided a policy titled "P.I.T. Crew -Proactive Interventions &amp; Treatment Crew", undated and indicated the policy was the currently used by the facility. The policy indicated "...Psychotropic Medication Monitoring: The goal is to reduce or discontinue the use of psychotropic medication depending on the needs of the resident...."</p> <p>3.1-48(a)(4)</p>			

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F 0465 SS=D Bldg. 00	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation, interview and record review, the facility failed to ensure resident rooms were free from odors. This had the potential to affect 4 of 62 residents who reside in the facility.</p> <p>Findings include:</p> <p>On 10/01/2015 at 9:13 a.m., Resident #57's bathroom was observed to have a very strong urine odor. An interview with Resident #57 indicated he/she did not use the bathroom very much because "other people" go in there. The bathroom was a shared bathroom with another room.</p> <p>On 10/01/2015 at 2:23 p.m., Resident #45 room was observed to have an odor which was stronger by his recliner and the wheelchair but the bathroom in his room also had a strong urine odor.</p> <p>On 10/05/2015 at 1:45 p.m., Rooms 304 and 216 were observed to have a strong</p>	F 0465	<p>It is the intent of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. Rooms 304 and 216 have been deep cleaned. 2. Rounds have been completed on all resident rooms and deep cleaning has been completed on any rooms with identified odors. 3. All staff has been re-educated with regards to facility policy on safe/ functional/ sanitary/ comfortable environment by SDC/ designee. 4. PI tool has been developed that will identify safe/ functional/ sanitary and comfortable environment to be completed by the Maintenance Director/designee weekly x 4 and monthly x 3 and will be reviewed by Director of Maintenance in the QAPI meeting until such time as substantial compliance has been achieved.</p>	11/06/2015

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F 9999  Bldg. 00	odor.  During an environmental tour on 10/05/2015 at 2:17 p.m., the Maintenance Director indicated there was a strong odor in room 216 and in room 204. He further indicated that he believed the odor in room 304 was coming from the tile in the residents bathroom and that the tile needed to be pulled up and that it was sometimes hard to get the resident to the bathroom to urinate.  3.1-19(f)	F 9999	It is the intent of the facility to ensure that each employee and each resident receives tuberculin testing as outlined in the regulation. 1. Employee # 79 will receive a 2 step PPD. Resident	11/06/2015
	3.1-14 Personnel (t) A physical examination shall be required for each employee of a facility			

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	<p>within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradurmal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. the tuberculin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve(12)months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p>		<p>#31 received a mantoux on 2/20/15. Facility will perform 100% audit of PPD's for both residents and stakeholders to ensure that staff and resident PPD's have been administered timely. 2. SCC will educate the SDC and Licensed Nursing staff with regards to resident admission requirements for tuberculin skin testing, as well as new employee hire requirements related to tuberculin skin testing. 3. PI tool will be developed to ensure PPD's are given and read timely for both residents and newly hired staff to be completed by the SDC weekly x 4 and monthly x 3 and will be presented by the DON/ designee to the QAPI committee monthly until the committee is satisfied that substantial compliance has been achieved in both areas.</p>	

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	<p>This State rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure 1 of 10 employees sampled ( Employee #79) received a second step tuberculosis test within 2 to 3 weeks of the first step tuberculosis testing.</p> <p>Findings include:</p> <p>A record review on 10/07/2015 at 11:16 a.m., indicated employee #79 received his/her first tuberculosis test on 3/6/2015 and the second tuberculosis test was not administered until 4/7/2015.</p> <p>A form received from Employee #80 on 10/07/2015 at 11:13 a.m., titled "Stakeholder Tuberculosis (TB) Test Form" stated "...PLEASE NOTE: Stakeholders are required to have a skin test upon hire (2nd Step)and at least yearly. Nursing staff (or assigned designee) must read all tests either 48 or 72 hours after administration. Failure to have your test read will require the test to be repeated. New stakeholders are required to have a second TB skin test administered and read fourteen (14)days after the initial testing. A single step TB</p>			

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	<p>skin test is required annually. Stakeholders with a history of positive skin tests will be required to have a chest x-ray upon hire and must complete a yearly TB questionnaire...."</p> <p>During an interview on 10/07/2015 at 11:13 a.m., Employee #80 indicated that the employee should have had the second step tuberculosis test sooner.</p> <p>3.1-14(t)(1)</p> <p>3.1-18 Infection Control Program (e) In addition, a tuberculin skin test shall be completed within three(3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two(72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>This State rule not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure 1 of 5 residents sampled (Resident #31) received a tuberculosis test upon admission to the facility.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/07/2015
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF BREMEN	STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506
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	<p>Finding includes:</p> <p>During a record review on 10/05/2015 at 9:23 a.m., a resident immunization form indicated Resident #31 was admitted on 2/3/2015 and was not given his/her first step tuberculosis test until 2/6/2015.</p> <p>During an interview on 10/05/2015 at 2:25 p.m., the Director of Nursing indicated that all residents are to receive their first step tuberculosis test within 24 hours of admission to the facility.</p> <p>On 10/7/2015 at 12:07 p.m., the Director of Nursing provided a policy titled, "Tuberculosis, Screening Residents Form" and indicated that policy was the one currently used by the facility. The policy indicated "...a. the facility will screen referrals for admission and readmission for information regarding exposure to, or symptoms of TB and will check results of recent (within 12 months) tuberculin skin tests (TST), blood assay for Mycobacterium tuberculosis (BAMT) or chest X-rays (CXR)...."</p> <p>3.1-18(e)</p>			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155474	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2015
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF BREMEN			STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LN BREMEN, IN 46506		
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