

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155270	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/20/2015
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NAME OF PROVIDER OR SUPPLIER CORE OF DALE	STREET ADDRESS, CITY, STATE, ZIP CODE 510 W MEDCALF ROAD DALE, IN 47523
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 16, 17, 18, 19, and 20, 2015.</p> <p>Facility number: 000170 Provider number: 155270 AIM number: 100287490</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicare: 1 Medicaid: 44 Other: 1 Total: 46</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on November 24, 2015.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or of conclusions set forth on the statement of deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state law. This Plan of Correction is submitted in order to respond to the allegations of noncompliance during complaint survey review concluding on 11/20/2015. Please accept this Plan of Correction as the provider's credible aggregation of compliance effective on 12/20/2015. We respectfully request a desk review for compliance.</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 0225 SS=D Bldg. 00	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review,</p>	F 0225	F 225 It is the Policy of this	12/20/2015	

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	<p>the facility failed to ensure a thorough investigation was completed for 1 of 3 allegations of abuse reviewed. (Resident #52)</p> <p>Findings Include:</p> <p>On 11/17/15 at 1:30 P.M., the facility provided a reportable incident that had occurred on 6/30/15 at 6:30 P.M., it included, but was not limited to, "6/30/15 I received a call from charge Nurse on this date at 6:30 pm She reported to me that this resident had a cousin [name of cousin] from Florida who had called and stated that He spoke to [name of resident] on his cell and that [name of resident] had stated that he was up in a chair for 4 hours today against his will, and that staff was not feeding him and that we were taking his phone away from him." The report continued to indicate Resident #52 had no injuries. The actions taken included notification of the Administrator, investigation beginning, and placing Resident #52 on 30 minute checks.</p> <p>The allegation named OT#5 as being involved in the allegation. The investigation lacked documentation of any other staff member involved in Resident #52's care that day. Documentation was lacking that staff had</p>		<p>facility to ensure that all allegations of abuse, neglect or mistreatment including injuries of unknown origin and misappropriation of resident property are reported immediately to the Administrator/designee in accordance with State law through established procedures. It is CORE Nursing policy that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. Resident # 52 suffered no ill effects from the alleged deficient practice. DON was made aware of allegation from family member who lived out of state at 6:30pm. This reported incident was reported to have occurred earlier in this day. An Investigation immediately begun, as this same DON was also there during this day, and was in andout of resident's room and had family meeting with resident #52 Healthcare Representative that day during these same hours, and with no reports made from any person during the time now being alleged. Allegation was reported using ISDH internet Gateway portal as soon as was possible per State law. All Residents have the potential to be affected from this alleged deficient practice and therefore by re-education and in-services and the development of more thorough procedures and a new standard Allegation</p>		

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	<p>been suspended pending an investigation. Documentation was also lacking other residents and staff members had been interviewed for the investigation.</p> <p>The facility follow up to the incident was added on 7/3/15 (untimed), it indicated the allegation had been unsubstantiated following a "thorough and immediate investigation"</p> <p>The investigation included a typed statement from OT#5 dated 7/1/15. The statement included "I was asked by nursing to assist with getting [name of resident] into a chair... I determined that a hoier lift was appropriate for the transfer due to Resident's functional status...I was not present for transfer to commode or BRODA [specialty wheel chair] chair..."</p> <p>During an interview with the Director of Nursing (DON) 11/19/15 at 2:45 P.M., she indicated on the allegation of abuse was reported to the facility 6/30/15 at 6:30 P.M. She further indicated the nurse on duty had received a phone call from Resident #52's family member that reported Resident #52 had claimed he had been left in the chair for four hours against his will, was not being fed, and staff had taken his phone. The DON indicated no staff had been suspended due to the staff involved being off duty at</p>		<p>Investigation Report Form, the facility will ensure that the residents are free of any forms of abuse and Administration will complete thorough investigations that are in accordance with State and Federal Regulations. Systemic Changes will be to update and include a new Standardized Facility Investigative Form and new Procedures form added to our Abuse and Unusual Occurrence Policy. These will be used for every allegation received and have specific times for the beginning, all interviews and ending of the investigations. Administrator/DON/Designee will meet after each allegation and investigation to review the Allegation Investigation Report Form for auditing so as to assure that all Investigations have been thorough and in accordance with State and Federal Regulations. These forms and all other documents will be forwarded to the QA committee and reviewed for complete compliance. This will now be on-going as a part of normal operations.</p>				

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	<p>the time the incident was reported. The DON indicated she had completed the investigation on the evening of 6/30/15 and the allegation was unsubstantiated.</p> <p>During an interview with the Administrator on 11/19/15 at 2:50 P.M., she indicated LPN #30, CNA #41, CNA #22 and CNA #24 were working on the hall that day. She further indicated Resident #52 had also indicated a male (OT #5) had been involved. The Administrator indicated the investigation into the allegation of abuse by Resident #52 was completed on 6/30/15. She indicated herself and the DON had talked to all staff involved and also had reviewed the facility video for evidence on 7/1/15. At that time the Administrator indicated no staff had been suspended.</p> <p>The facility daily sheet was reviewed on 11/19/15 at 3:00 P.M., It indicated LPN #30, and CNA #22 were all working on the hall that day. Through interview the facility indicated CNA #41 was also on staff on the East unit and not named on the day sheet.</p> <p>The time cards for the involved staff were provided by the facility on 11/19/15 at 3:00 P.M. They included the following:</p>			

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	<p>The time card for LPN #30 indicated she had returned to work on 7/1/15 at 6:00 A.M.</p> <p>The time card for CNA #22 indicated she had returned to work on 7/1/15 at 7:00 A.M.</p> <p>The time card for CNA #41 indicated she had returned to work on 7/1/15 at 7:00 A.M.</p> <p>The time card for OT #5 indicated he had returned to work on 7/1/15 at 4:45 A.M.</p> <p>A policy titled "ABUSE AND UNUSUAL OCCURRENCE DEFINED AND POLICY" dated 8/30/13 was provided on 11/18/15 3:20 P.M., by the DON. It included, but was not limited to, "CORE Nursing and Rehabilitation prohibits the mistreatment, neglect and abuse of residents and misappropriation of resident property by anyone including staff, family, friends ect. CORE has implemented the following processes in an effort to provide our residents and staff a safe and comfortable environment...Nurses and CNA's are to immediately, provide for the safety and security of residents effected and charge nurse is to suspend accused staff pending investigation..."</p>			

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F 0226 SS=D Bldg. 00	<p>A policy titled "ABUSE/UNUSUAL OCCURRENCE ADMINISTRATIVE INVESTIGATIVE/REPORTING POLICY" dated 10/30/14 included, but was not limited to, "...The initial report filed must contain information about a description of the occurrence, all involved residents and staff...a description of the actions taken by CORE in response to the situation, and actions taken by CORE to prevent further occurrence while investigation is ongoing...will have 5 days to complete a thorough investigation...A thorough investigation not only will include interviews with the resident and staff members involved..but also a number of other residents and staff members and family members...".</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure the facility</p>	F 0226	F226 It is the Policy of this facility to ensure that all allegations of abuse, neglect or	12/20/2015

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	<p>abuse policy was implemented in regard to a complete and through investigation had not been completed prior to allowing involved staff to return to work for 1 of 3 allegations reviewed. (Resident #52)</p> <p>Findings Include:</p> <p>On 11/17/15 at 1:30 P.M., the facility provided a reportable incident that had occurred on 6/30/15 at 6:30 P.M., it included, but was not limited to, "6/30/15 I received a call from charge Nurse on this date at 6:30pm She reported to me that this resident had a cousin [name of cousin] from Florida who had called and stated that He spoke to [name of resident] on his cell and that [name of resident] had stated that he was up in a chair for 4 hours today against his will, and that staff was not feeding him and that we were taking his phone away from him." The report continued to indicate Resident #52 had no injuries. The actions taken included notification of the Administrator, investigation beginning, and placing Resident #52 on 30 minute checks.</p> <p>The allegation named OT#5 as being involved in the allegation. The investigation lacked documentation of any other staff member involved in Resident #52's care that day.</p>		<p>mistreatment including injuries of unknown origin and misappropriation of resident property are reported immediately to the Administrator/designee in accordance with State law through established procedures. It is CORE Nursing policy that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. All staff involved in alleged deficient practice will be suspended and not allowed to return to work pending the documentation of a timed completion of the investigation. Resident # 52 suffered no ill effects from the alleged deficient practice. DON was made aware of allegation from family member who lived out of state at 6:30pm. This reported incident was reported to have occurred earlier in this day. An Investigation immediately begun, as this same DON was also there during this day, and was in and out of resident's room and had family meeting with resident#52 Healthcare Representative that day and during these hours and with no reports made from any person during the time now being alleged. Allegation was reported using ISDH internet Gateway portal as soon as was possible per State law. All Residents have the potential to be affected from this alleged deficient practice and therefore by re-education and in-services and the development</p>		

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	<p>Documentation was lacking that staff had been suspended pending an investigation. Documentation was lacking other residents and staff members had been interviewed for the investigation.</p> <p>The facility follow up to the incident was added on 7/3/15 (untimed), it indicated the allegation had been unsubstantiated following a "thorough and immediate investigation"</p> <p>The investigation included a typed statement from OT#5 dated 7/1/15. The statement included "I was asked by nursing to assist with getting [name of resident] into a chair... I determined that a hooyer lift was appropriate for the transfer due to Resident's functional status...I was not present for transfer to commode or BRODA [specialty wheel chair] chair..."</p> <p>During an interview with the Director of Nursing (DON) 11/19/15 at 2:45 P.M., she indicated the allegation of abuse was reported to the facility 6/30/15 at 6:30 P.M. She further indicated the nurse on duty had received a phone call from Resident #52's family member that reported Resident #52 had claimed he had been left in the chair for four hours against his will, was not being fed, and staff had taken his phone. The DON indicated no staff had been suspended</p>		<p>of more thorough policy and procedures and a new standard Allegation Investigation Report Form,the facility will ensure that the residents are free of any forms of abuse and Administration will complete thorough investigations including completedocumentation of all interviews with all involved staff and that the times ofall interviews are documented. Systemic Changes will be to update and include a new Standardized Facility Investigative Form and new Procedures form added to ourAbuse and Unusual Occurrence Policy. These will be implemented for every allegation received and havespecific times for the beginning, all interviews and ending time ofinvestigations. All staff involved in allegation will be suspended and timesdocumented on the standardized form. No staff will be allowed to return to facility until the thorough investigation is completed and deemed as unsubstantiated and timed as such. If allegation is substantiated the appropriate disciplinary action will be taken up to and including termination andreported to State survey and certification agency. Administrator/DON/Designee will meet after each allegation and investigation to review the Investigative procedure, documentations and Allegation Investigation Report Form for</p>		

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	<p>due to the staff involved being off duty at the time the incident was reported. The DON indicated she had completed the investigation on the evening of 6/30/15 and the allegation was unsubstantiated.</p> <p>During an interview with the Administrator on 11/19/15 at 2:50 P.M., she indicated LPN #30, CNA #41, CNA #22 and CNA #24 were working on the hall that day. She further indicated Resident #52 had also indicated a male (OT #5) had been involved. The Administrator indicated the investigation into the allegation of abuse by Resident #52 was completed on 6/30/15. She indicated herself and the DON had talked to all staff involved and also had reviewed the facility video evidence on 7/1/15. At that time the Administrator indicated no staff had been suspended.</p> <p>The facility daily sheet was reviewed on 11/19/15 at 3:00 P.M., It indicated LPN #30, and CNA #22 were all working on the hall that day. Through interview the facility indicated CNA #41 was also on staff on the East unit and not named on the day sheet.</p> <p>The time cards for the involved staff were provided by the facility on 11/19/15 at 3:00 P.M. They included the following:</p>		<p>auditing, so as to assure that all investigations will be thorough and in accordance with CORE Nursing Abuse and Unusual Occurrence Policy/Procedure and be in compliance with State and Federal Regulations. These forms and all other documents will be forwarded to the QA committee and reviewed for complete compliance. These Audits will now be on-going as a part of normal operations.</p>	

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	<p>The time card for LPN #30 indicated she had returned to work on 7/1/15 at 6:00 A.M.</p> <p>The time card for CNA #22 indicated she had returned to work on 7/1/15 at 7:00 A.M.</p> <p>The time card for CNA #41 indicated she had returned to work on 7/1/15 at 7:00 A.M.</p> <p>The time card for OT#5 indicated he had returned to work on 7/1/15 at 4:45 A.M.</p> <p>A policy titled "ABUSE AND UNUSUAL OCCURRENCE DEFINED AND POLICY" dated 8/30/13 was provided on 11/18/15 3:20 P.M., by the DON. It included, but was not limited to, "CORE Nursing and Rehabilitation prohibits the mistreatment, neglect and abuse of residents and misappropriation of resident property by anyone including staff, family, friends ect. CORE has implemented the following processes in an effort to provide our residents and staff a safe and comfortable environment...Nurses and CNA's are to immediately, provide for the safety and security of residents effected and charge nurse is to suspend accused staff pending investigation..."</p>			

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F 0258 SS=D Bldg. 00	<p>A policy titled "ABUSE/UNUSUAL OCCURRENCE ADMINISTRATIVE INVESTIGATIVE/REPORTING POLICY" dated 10/30/14 included, but was not limited to, "...The initial report filed must contain information about a description of the occurrence, all involved residents and staff...a description of the actions taken by CORE in response to the situation, and actions taken by CORE to prevent further occurrence while investigation is ongoing...will have 5 days to complete a thorough investigation...A thorough investigation not only will include interviews with the resident and staff members involved..but also a number of other residents and staff members and family members...".</p> <p>3.1-28(a)</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels.</p> <p>Based on observation,interview, and record review, the facility failed to ensure residents (Residents #47, 3, 7) and staff</p>	F 0258	F 258 It is the policy of this facility to provide for the maintenance of a homelike environment and comfortable sound levels. Resident #19 and #23 were the residents affected	12/20/2015			

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	<p>did not loudly yell through the hallways for 2 of 2 residents who met the criteria for uncomfortable sound levels on 2 of 2 units during 4 of 5 survey days. (Resident #19, Resident #23,)</p> <p>Findings include:</p> <p>1. During an interview on 11/16/15 at 10:09 A.M., Resident #19 was observed to be wearing headphones. Resident #19 indicated there was a lot of noise in the hall outside the room. "I wear these headphones because it drives me crazy to listen to it." Resident #19 further indicated the noise was especially disturbing in the mornings. Resident #19 indicated the source of the noise was residents yelling out and staff yelling at each other.</p> <p>The clinical record for Resident #19 was reviewed 11/16/14 at 1:35 P.M. It included a Quarterly MDS (Minimum Data Set) assessment dated 8/31/15 which indicated Resident #19 experienced mild cognitive impairment.</p> <p>During an observation of the West Unit on 11/16/14 at 8:04 A.M., Resident #47 was heard yelling. An unidentified staff member was walking down the hall from the dining room and indicated it was ok because that resident yelled a lot.</p>				<p>by this alleged deficiency. All residents have the potential to be affected by this alleged deficiency. All interviewable residents will be interviewed to be identified if they have been adversely affected by uncomfortable noise levels. Interviews to be discussed at daily Interdisciplinary Team meeting for review. Headphones and/or ear plugs will be provided upon request. Residents #3 #47 #7 All have differing reasons that they yell out at times all care plans have been reviewed and updated and In-house Psychologist to re-evaluate. Resident #3 new interventions have included Music therapy, increased time with 1-1 with activity director, nursing to assess possible pain vs. behavioral. Resident #47 new interventions include music therapy, aromatherapy, increased time with activity director, medication review per in-house psychologist. Resident #7 new interventions included when she is finished with her meal and begins to yell to go to bed she is to be offered activity books or other diversional activities until meals are completed and staff is able to lay her down. Systemic Changes will be to review and update Care plans of all residents who are affected by uncomfortable noise as well as the residents who are causing some of the uncomfortable</p>		

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	<p>During an observation of the West Unit on 11/16/15 at 10:07 A.M., Resident #47 was heard yelling repeatedly, "Ahhhhh, Ahhhhh" for 3 minutes.</p> <p>During an observation on the West Unit on 11/17/15 at 7:30 A.M., a loud alarm was sounding continuously from 7:30 A.M. to 9:30 A.M. At that time, the Director of Nursing indicated the maintenance staff was working on the sprinkler system.</p> <p>During an observation of the West Unit on 11/19/15 at 8:05 A.M., Resident #3 was lying in bed and was repeatedly yelling a staff member's name in a loud manner. At that time, CNA #12 indicated Resident #3 could use her call light, but she just yelled for someone to assist instead of using the call light.</p> <p>During an observation of the West Unit on 11/19/15 at 9:25 A.M., Resident #3 was lying in bed and was heard repeatedly yelling, "Hurry up! Hurry up!" in a loud manner. At that time, CNA # 2 entered Resident #3's room and shut the door.</p> <p>During an observation of the West Unit on 11/19/15 at 11:04 A.M., Resident #47 was heard repeatedly yelling</p>		<p>noises. This alleged deficiency will be reviewed at least weekly at our daily IDT meetings and care plans can be updated and interventions developed by team. Systemic changes concerning staff-initiated uncomfortable noise levels will be to re-educate and in-service all staff of CORE quarterly on noise and the affect it has on residents in healthcare facilities. Re-educations will be given with all infractions, and disciplinary action will ensue with repeated offenses. Administrator/DON/Designee will perform audits with 3 random residents to assure that noise levels are comfortable and that environment is homelike 5 times weekly for 1 month, 3 times weekly for 1 month and then weekly for the remaining 10 months. Results will be forwarded to the QA committee for further suggestions or recommendations.</p>		

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	<p>unintelligible speech in a loud manner for 3 minutes.</p> <p>During an observation of the West Unit on 11/19/15 at 11:21 A.M., Resident #47 was heard repeatedly yelling unintelligible speech in a loud manner for 2 minutes.</p> <p>During an observation of the West Unit on 11/19/15 at 11:30 A.M., Resident #47 was heard repeatedly yelling unintelligible speech in a loud manner for 2 minutes.</p> <p>During an observation of the West Unit on 11/19/15 at 11:57 A.M., Resident #47 was heard yelling 22 times, "I want a drink." LPN #7 was observed standing at the medication cart located 4 residents' rooms away where she yelled to the CNA down the hall, "Is somebody getting that lady a drink?"</p> <p>2. During an interview on 11/17/15 at 2:20 P.M., Resident #23 indicated the noise created by residents yelling from their rooms and in the hall was very loud and bothered him. Resident #23 indicated the noise was especially noticeable during the evening hours.</p> <p>The clinical record for Resident #23 was reviewed 11/16/15 at 1:35 P.M. It</p>			

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	<p>included a Quarterly MDS (Minimum Data Set) assessment dated 8/31/15 which indicated Resident #19 experienced no cognitive impairment.</p> <p>During an observation on East Unit on 11/19/15 at 7:20 A.M., CNA #1 was standing in the door of Resident #108's room and yelled, "Come here a minute." to the Administrator and CNA #13, who were standing by the meal cart located across the hall from the Administrator's office.</p> <p>During an observation of the East Unit on 11/19/15 at 7:45 A.M., Resident #7 was heard yelling unintelligible speech in a loud manner for 2 minutes.</p> <p>During an interview on 11/19/15 at 8:30 A.M., CNA #12 indicated Resident #7 yelled like that whenever she wanted to go to bed. CNA #12 further indicated Resident #7 could use her call light, but that Resident #7 sometimes just yelled instead of using her call light.</p> <p>During an observation on East Unit on 11/19/15 at 9:40 A.M., LPN #6 was standing near the entry door to the administrative office and yelled to LPN #7, who was standing outside room 106, the following: "(Nurse's name) they are down here. (Nurse's name) they are down</p>			

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	<p>here."</p> <p>During an interview on 11/19/15 at 2:15 P.M., the Administrator indicated the facility had a policy for noise levels and that an inservice related to controlling the noise levels in the facility had recently been completed.</p> <p>An untitled Policy and Procedure for managing environmental sound dated 10/15 was provided by the Director of Nursing on 11/19/15 at 2:50 P.M., and it read as follows: "It is the policy of this facility to provide and maintain a peaceful and pleasing environment. It is our goal to be a homelike facility and that sound levels do not interfere with the residents pleasant living environment...All attempts should be made to keep noise level low as possible to reduce stress and irritation of our residents..."</p> <p>3.1-32(a)</p>						
F 0312 SS=D Bldg. 00	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>						

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	<p>Based on observation, interview, and record review, the facility failed to ensure a resident frequently incontinent of urine received assistance for incontinence care and hygiene for 1 of 1 residents reviewed for urinary incontinence. (Resident #5)</p> <p>Findings included:</p> <p>On 11/17/15 at 10:12 A.M., Resident #5 was observed lying in bed with his eyes closed. Resident #5 was observed to have a strong odor of urine and food debris on his face and clothing.</p> <p>On 11/17/15 at 4:32 P.M., Resident #5 was observed sitting up in a wheelchair in the hallway. Resident #5 was observed at that time to have a strong urine odor and large urine stain down the right side of his pants.</p> <p>The clinical record for Resident #5 was reviewed on 11/18/15 at 9:29 A.M., his diagnoses included but were not limited to, Bi polar, congestive heart failure, anxiety, depression, and dementia.</p> <p>The care plans were reviewed and included, but were not limited to, activities of daily living (ADL) self care deficit or potential decline in function, related to toileting, dressing and personal hygiene initiated 6/15/15. The</p>	F 0312	F 312 It is the policy of this facility that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene. Resident # 5 suffered no ill effects from the alleged deficiency. CNA #13 was immediately re-educated on perineal care after incontinence. Resident #5 was offered a scheduled toileting program and he declined. All semi dependent residents in the facility have the potential to be affected by the alleged deficiency. All nursing department staff will be re-educated and in-serviced on importance of proper incontinence care with residents that need assistance. Systemic changes are that in addition to our current Incontinence care policies, all similarly like residents who prefer to care for themselves with toileting and other hygiene needs, be identified and Care planned with interventions that are individualized with strategies for compliance with assistance. Encouragement and care offered and documentation of their acceptance or denial of our assistance offered. Interdisciplinary Team members to assess and evaluate daily and change care plans to meet each resident's preference while continuing to provide needed care. DON/Designee will perform	12/20/2015			

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	<p>interventions included, but were not limited to, assess/ record self care status and changes, encourage exercise during daily care, provide only the amount of assistance/supervision that is needed with ADL's.</p> <p>A care plan for alteration in urinary elimination initiated 6/15/15 indicated Resident #5 experienced urinary incontinence, related to diuretic use, stress incontinence, lack of sensation and impaired mobility. The interventions included, but were not limited to, remind/cue resident to go to the bathroom, answer call light promptly, provide pericare after each episode.</p> <p>The Minimum Date Set assessment (MDS) dated 9/30/15, indicated Resident #5 required extensive assistance of 1 with personal hygiene, frequent incontinence of urine and bowel movements.</p> <p>On 11/18/15 at 2:00 P.M., the CNA assignment sheet dated 11/18/15 was reviewed and indicated Resident #5 was ambulatory, unsteady requiring assistance, incontinent of urine, The CNA assignment sheet indicated Resident #5 required much encouragement to shower, shave and complete ADL's.</p>		<p>audits on 3 random (and similar to resident #5) residents completed 5 times weekly for 1 month, then 3 times weekly for one month, then weekly indefinitely for at least one year with results forwarded to QA committee for further suggestions or recommendations.</p>				

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	<p>During an observation on 11/18/15 at 2:50 P.M., Resident #5 was observed ambulating from the nursing station to his room. Resident #5 was observed to have a strong urine odor and his pants were sagging exposing the top of his buttock.</p> <p>During an interview with CNA #13 on 11/18/15 at 2:55 P.M., she indicated Resident #5 often preferred to complete his own ADL care however they were responsible for cueing him to complete care and had to encourage him to bathe and change clothing. During an observation of peri care at that time, Resident #5 was observed to be completely soaked through his incontinence brief. CNA #13 assisted Resident #5 to apply a new brief and pants. No peri care was observed to be provided. CNA #13 indicated she was unaware of the last time Resident #5 had been assisted to or cued to use the restroom.</p> <p>The facility provided an undated policy for perineal care on 11/18/15 at 3:50 P.M., it included, but was not limited to, "...For male residents, wash the penis from the urethral opening or tip of the penis, pull back the foreskin for uncircumcised males and clean under it, wash the scrotum, pay attention to skin</p>						

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F 0323 SS=D Bldg. 00	<p>folds, rinse and dry... Wash, rinse and dry buttocks and peri-anal area without contaminating perineal area...</p> <p>An undated policy titled "Incontinent Policy" was provided on 11/18/15 at 3:50 P.M., it included" An interdisciplinary, individualized continence care plan based on resident preference and assessed needs will be developed for each resident to maximize independence, comfort and dignity and reviewed quarterly or after any change in condition that affects continence....Toileting: The process of encouraging the resident to use some type of containment device in which to void...Toileting is for the purpose of voiding and not for just changing briefs...".</p> <p>3.1-38(a)(3)(c)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure cognitive impaired residents at high risk</p>	F 0323	F 323 It is the policy of CORE Nursing that our resident's environment remain	12/20/2015			

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	<p>to experience an accident were provided supervision or immediate effective interventions were implemented to prevent accidents for 2 of 3 residents who met the criteria for review of accidents. (Resident #40 and #37)</p> <p>Findings include:</p> <p>1. On 11/17/15 at 3:15 P.M., Resident #40 was observed sitting in his wheelchair in the hall. Dark purple bruising was noted around and under his right eye and right forehead.</p> <p>On 11/18/15 at 9:22 A.M., Resident #40's clinical record was reviewed. His admission Minimum Data Set assessment (MDS) dated 9/23/15, indicated extensive assistance of 2 or more staff needed for bed mobility, transfer, and walking. The assessment also indicated moderately impaired decision making skills with cues and supervision required.</p> <p>An admission fall risk assessment dated 9/16/15, indicated a total score of 18 that indicated a high risk for falls. Diagnoses included but were not limited to, anxiety, intermittent explosive disorder, and dysphagia.</p> <p>His fall care plan initiated 9/20/15, included, but was not limited to an</p>		<p>as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Residents # 40 and #37 were affected by alleged deficiency. Both residents Care Plans were reviewed and updated to meet their safety needs.</p> <p>All residents in this facility have the potential to be affected by the alleged deficiency. All residents care plans will be reviewed and updated for their own individualized safety needs. Any resident that is at risk for choking will be dining in the main dining room (unless otherwise contraindicated), but will always be served with constant staff supervision. Any resident who continues to fall after numerous interventions have failed, will be placed on line of sight to provide for their safety.</p> <p>Systemic changes will be to in-service nurses on need for immediate and new interventions with each fall and documentation in nurses notes of new interventions and their effectiveness. Falls to be reported daily at Interdisciplinary Team Meeting for collaboration and care plan updating. All nursing staff to be re-educated and in-serviced on supervision of residents during meals and that both Dining rooms are to be monitored when trays are served until all food has been removed. Hallways are to be free of hazards, such as Hoyer lifts,</p>				

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	<p>intervention dated 10/8/15 of "...Close supervision line of sight when up..." A nutritional risk care plan initiated 11/9/15, included the intervention, "... Monitor for S [signs] /S[symptoms] of aspiration..."</p> <p>A nursing progress note dated 11/14/15 at 4:30 A.M., indicated Resident #40 was found in his room on the floor. Documentation indicated he had a laceration above his right eyebrow measuring 2.4 x 1 cm (centimeters) and a skin tear to the right elbow area measuring 1.8 x 1.4 cm.</p> <p>On 11/16/15 at 12:05 P.M., Resident # 40 had his lunch tray delivered by CNA # 4 in the east unit dining room and after tray set up Resident #40 began feeding himself. CNA #4 then exited the dining room and the other residents in the East Unit dining area had not receive their trays. Resident #40 continued eating without any staff present in the East Unit dining area.</p> <p>On 11/16/15 at 12:10 P.M., the Director of Nursing (DON) entered the East Unit dining area and indicated Resident #40 was on thickened liquids and indicated the CNA should not have left the dining area after delivering Resident #40's tray. The DON indicated normally there was a</p>		<p>when not in use. DON/Designee to perform audits on 3 random residents, to assure safety care plans updated and nursing notes have thorough documentation of incidents with interventions as well as effectiveness of interventions, completed 5 times weekly times one month, 3 times weekly times one month and then weekly for a total of one year with results forwarded to the QA committee for further suggestions/comments.</p>	

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	<p>nurse at the nurses station on the East Unit across from the dining area to monitor residents eating in the dining area.</p> <p>The DON indicated the facility was short of staff today and the Minimum Data Set assessment (MDS) Nurse was filling in for the East Unit nurse. She indicated the MDS nurse was passing medication down the east unit hall and had been unaware of supervision needed for Resident #40 who had a diagnosis of dysphagia (difficult swallowing).</p> <p>Review of Resident #40's dietary tray slip at that time indicated a pureed diet with honey thick liquids.</p> <p>On 11/16/15 at 12:20 P.M., the DON interviewed CNA #4 and CNA #6 who were now present in the east unit dining area. CNA #6 indicated Resident #40 had received his tray early due to he had been "wandering."</p> <p>On 11/18/15 at 1:40 P.M., Resident #40 was observed unsupervised by staff in the east hall area in his wheelchair entangled in a hoyer device (mechanical lift) that was placed along the east hall wall. One of the metal bars of the mechanical lift was observed to strike his cheek/chin area.</p>			

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	<p>A nursing progress note dated 11/18/15 at 2:50 P.M., indicated, "THERAPIST CAME TO THIS WRITER et [and] STATED THAT HE WAS INFORMED THAT RESIDENT WAS CAUGHT UP IN THE HOYER LIFT c [with] HIS W/C @ 1343 [1:43 P.M.] et [and] THE BAR TO THE LIFT MADE CONTACT c [with] RESIDENTS CHIN RESIDENT WAS REMOVED/REDIRECTED @ 1344 BY SAID [sic] THERAPIST..."</p> <p>On 11/19/15 at 10:58 A.M., the DON was made aware of the problem of lack of supervision for Resident #40, a dysphagia resident on 11/16/15 at the noon meal and on 11/18/15 when Resident #40, had entangled himself in a hoier lift. The DON indicated, at that time, she understood the problem.</p> <p>A facility policy entitled, "NURSING DEPARTMENT: RESIDENT DINING SERVICES" with policy date of 6/12 was reviewed on 11/19/15 at 11:00 A.M. The policy included, but was not limited to, "It is the policy of this facility to maintain a safe environment during dining services. It is the responsibility of the Nursing department, or any certified dining personnel, to monitor for unsafe dining including, but not limited to, choking on food/fluids and residents needing assistance or on mechanically</p>			

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	<p>altered foods or fluids... "... Dining areas on East and West will be attended at all times by nursing or a certified dining person. At NO TIME will the residents in any dining room be left unattended while eating. Personnel are to be with each dining room resident until their foods and fluids are completely consumed..."</p> <p>2. Resident #37 was observed on 11/16/15 at 9:05 A.M., sitting in a wheelchair with a tab alarm attached to the back of his/her shirt.</p> <p>A CNA Assignment Sheet provided by DON (Director of Nursing) on 11/16/15 at 9:25 A.M. indicated Resident #37 was at risk to experience a fall and included a notation of, "...sometimes...functional status changes from amb [ambulatory] to ext [extensive] asst [assistance] on the same day even..."</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment dated 6/6/15 indicated Resident #37 experienced minimal cognitive impairment, unsteady balance during transitions and walking, and required the limited assistance of one staff for transfers.</p> <p>The most recent Annual MDS assessment dated 9/12/15 indicated Resident #37</p>			

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	<p>experienced minimal cognitive impairment, unsteady balance during transitions and walking, and required the extensive assistance of two staff for transfers.</p> <p>During an interview on 11/17/2015 at 9:04 A.M., the DON (Director of Nursing) indicated Resident #37 had recently developed pneumonia, experienced increased confusion, and had fallen 2 or more times in the previous 30 days.</p> <p>The clinical record of Resident #37 was reviewed on 11/18/15 at 8:38 A.M. The record indicated the diagnoses of Resident #37 included, but were not limited to, attention deficit disorder, chronic kidney disease, anxiety, depression, Parkinson's disease, borderline personality disorder, seizure disorder, and pneumonia.</p> <p>A Care Plan for Falls dated 9/12/15 indicated the safety interventions for Resident #37 included: "Use fall risk assessment to identify risk factors, Report falls to MD [physician]/responsible party, Monitor for side effects of any drug that can cause gait disturbance, orthostatic hypotension, weakness, sedation, vertigo</p>			

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	<p>[dizziness], change in mental status (if noted, report to RN), Report to MD any negative side effects associated with resident medication use, Provide environmental adaptations: half rails as enabler, call light within reach, Provide/monitor use of adaptive devices: walker prn, wheelchair prn, Remind resident and reinforce safety awareness, Lock breaks [sic] on bed, chair etc [et cetera] before transferring, Educate/remind resident to request assistance prior to ambulation, Appropriate footwear, Referral for screen & [and] treatment as needed PT [Physical Therapy] PRN [as needed], OT [Occupational Therapy] PRN, Mental Health, Provide resident/family teaching to include: Safety measures to reduce fall risk, What to do if fall occurs, How to fall, Provide restorative nursing, 15 min [checks]/PT eval, ATB [antibiotic] for infection, Anti-skid strips BR [bathroom], No use of chair stools, Moved closer to nurses [sic] station for supervision, Resident changed to a different W/C [wheel chair], Resident preference-prefers not to have shoelaces in shoes"</p>			

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	<p>A Nursing Assessment dated 9/12/15 indicated Resident #37 was easily distracted, experienced disorganized thinking, and was not at risk to experience a fall.</p> <p>Fall #1: A Nursing note dated 10/3/15 at 2:25 P.M. indicated, "While resident went to sit in rocking chair missed rocking chair and sat on floor..." The note lacked any documentation an immediate intervention was implemented or supervision was provided.</p> <p>A Care Plan for Falls dated 10/3/15 included a new interventions of, "Medication review, MD consult"</p> <p>A Fall Risk Assessment dated 10/4/15 indicated Resident #37 was at high risk to experience a fall.</p> <p>During an interview on 11/18/15 at 11:47 A.M., the DON indicated the immediate intervention to ensure the safety of Resident #37 was resident education and to request a medication review. The DON further indicated, at that time, the medication review was eventually denied.</p> <p>Fall #2: A Nursing note dated 10/28/15 at 7:15 P.M., indicated, "...[increased] confusion..."</p>			

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	<p>A Nursing note dated 10/29/15 at 10:05 A.M. indicated, "...Resident sluggish not acting usual self. Speech slurred..."</p> <p>A Nursing note dated 10/29/15 at 11:10 A.M. indicated, "Late entry...resident attempting to get in bed, found...kneeling at the bedside..." The note lacked any documentation an immediate intervention was implemented or supervision was provided.</p> <p>A Nursing note dated 10/29/15 at 12:30 P.M. indicated, "Summoned to rom [room] per staff Res [resident] lying on floor..." The note lacked any documentation an immediate intervention was implemented or supervision was provided.</p> <p>A Fall Risk Assessment dated 10/29/15 indicated Resident #37 was at high risk to experience a fall.</p> <p>A Care Plan for Falls dated 10/29/15 indicated a new intervention of, "CXR [Chest X-ray) et [and] Ua [urinalysis] d/t [due to] s/s [signs/symptoms] illness"</p> <p>During an interview on 11/18/15 at 11:49 A.M., the DON indicated the immediate intervention to ensure the safety of Resident #37 was resident education.</p>			

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	<p>Fall #3: A Nursing note dated 11/1/15 at 10:40 A.M. indicated, "Room-mate + [and] CNA stated that resident sitting on floor...put on q [every] 15 min checks for now..." The note lacked any documentation a new, immediate intervention was implemented or supervision was provided.</p> <p>A Fall Risk Assessment dated 11/2/15 indicated Resident #37 was at high risk to experience a fall.</p> <p>During an interview on 11/18/15 at 11:52 A.M., the DON indicated no new, immediate intervention was initiated to ensure the safety of Resident #37 after Fall #3. The DON further indicated, at that time, Resident #37 experienced a second unwitnessed fall (Fall #4) on 11/1/15 at 3:45 P.M. and was found sitting on floor, kneeling at bedside. The DON then indicated no documentation could be provided to indicate an immediate intervention was implemented or supervision was provided to ensure the safety of Resident #37 after Fall #4.</p> <p>Fall #5: A Nursing note dated 11/2/15 at 8:15 P.M., indicated, "...Res [resident] fell...while attempting to get out of bed. Found on floor beside bed...moved to bed with siderails...Bed alarm placed et</p>			

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	<p>functioning..." The note lacked any documentation a new, immediate intervention was implemented or supervision was provided.</p> <p>During an interview on 11/18/15 at 11:57 A.M., the DON indicated Resident #37 had changed rooms, was provided a bed without siderails, and experienced a fall. The DON further indicated the immediate intervention to ensure the safety of Resident #37 was to provide siderails to the new bed. The DON then indicated no new intervention had been initiated or supervision had been provided to ensure the safety of Resident #37.</p> <p>Fall #6: A Nursing note dated 11/11/15 9:30 A.M. indicated, "...entered resident's room alarm sounding resident noted to be on floor...new orders obtained to change alarms to tab alarms in w/c + bed...will keep resident at nurse's desk or with in supervision of nursing staff..."</p> <p>A Fall Risk Assessment dated 11/11/15 indicated Resident #37 was at high risk to experience a fall.</p> <p>A Special Resident Information form dated 11/16/15, provided by the SSD (Social Service Designee), indicated Resident #37 required, "...encourage</p>			

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	<p>moving staying busy...activities and walking/exercises...report insomnia...eat on east...using wheelchair... has alarms...monitor delusions..."</p> <p>During an interview on 11/18/15 at 12:00 P.M., the DON indicated Resident #37 experienced Fall #6 because staff couldn't get to the resident fast enough and the chair pad alarm was ineffective.</p> <p>During an interview on 11/18/15 at 11:52 A.M., the DON indicated immediate, effective interventions were not implemented and supervision was not provided after each fall. The DON further indicated immediate, effective interventions should have been implemented or supervision should have been provided to ensure the safety of Resident #37.</p> <p>During an interview on 11/19/15 at 2:16 P.M. the DON indicated no documentation could be provided to indicate Resident #37 was provided 15 minute checks before 11/4/15 at 7:00 A.M.</p> <p>A Policy and Procedure for Falls provided by the DON on 11/19/15 at 11:30 A.M., indicated, "...If a Resident Falls...3. Recognize the current care plan has failed. 4. Adjust/add intervention(s)</p>			

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	for improved protection..." 3.1-45(a)(2)				