

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00176441.</p> <p>Complaint IN00176441 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F282.</p> <p>Survey date: June 25, 2015</p> <p>Facility number: 000485 Provider number: 155655 AIM number: 100291190</p> <p>Census bed type: SNF/NF: 167 Residential: 122 Total: 289</p> <p>Census payor type: Medicare: 11 Medicaid: 122 Other: 156 Total: 289</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the Power of Attorney (POA) was notified when there was an accident for 1 of 4 residents reviewed for family/responsible party</p>	F 0157	The filing of this plan of correction does not constitute an admission that the alleged deficiencies exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulation and	07/25/2015	

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	<p>notification in a sample of 4 (Resident B). The facility also failed to notify the POA for a new medication for 1 of 4 residents reviewed for notification. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident (B) was reviewed on 6/24/15 at 10:00 a.m. Diagnoses for Resident (B) included, but were not limited to, congestive heart failure, chronic airway obstruction, hypertension, aphasia and depression. Resident (B) was severely cognitively impaired. Resident B had appointed a family member as his POA.</p> <p>Nursing notes, dated 2/15/15 at 6:22 p.m., indicated Resident B fell forward, out of his wheelchair and onto the floor. Resident B had an abrasion noted below his right eye, right cheek and nose. A hematoma was noted above his right eye/nose area. He had a skin tear on his right hand. The note indicated a communication form was filled out and placed in the communication book to notify the doctor.</p> <p>Review of the communication form, dated 2/15/14 at 6:30 p.m., indicated Resident B "face planted onto the carpet." The note indicated Resident B</p>		<p>continue to provide quality care. We respectfully request a desk review.</p> <ul style="list-style-type: none"> The family of Resident B was notified of the fall and medication ordered. All residents who had fallen in the past 30 days and/or had a medication change since 6/19/15 were audited for notification of responsible parties. All families that had not been notified of changes were notified by 7/10/15. All licensed nurses were re-educated on New Order Verification and the Incident Report Policy with the education completed by 07/10/15. New physician orders and falls notification will be reviewed daily by the DON/Designee on regular business days for 30 days, weekly for 3 months, monthly for 6 months, and ongoing thereafter until 100% of the threshold is achieved. The QAPI committee, chaired by the Administrator, will oversee compliance with the Director of Nursing/Designee having responsibility reporting. Systemic changes will be completed by July 25, 2015. 	

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	<p>complained of a headache and had a hematoma, multiple abrasions to the right side of his face and head and a skin tear on his right hand. Steri-strips were applied to the hand. The note indicated a new order had been written.</p> <p>Review of a physician's order, dated 2/16/15, indicated to offer ice to the resident's face four times daily for 20 minutes for 3 days.</p> <p>A nursing note, dated 2/16/15 at 2:45 p.m., indicated a family member was called after the new order for the ice was given. The nursing note indicated the #1 contact was notified of the new order.</p> <p>A nursing note, dated 5/1/15 at 1:05 a.m., indicated a new order was received to start Lexapro (anti-depressant medication) for depression.</p> <p>A nursing note, dated 5/1/15 at 10:20 a.m., indicated Resident B had begun Lexapro and did not show any adverse symptoms.</p> <p>A nursing note, dated 5/6/15 at 1:02 p.m., indicated no adverse mood or behaviors noted due to Lexapro being discontinued.</p> <p>During an interview on 5/25/15 at 3:45 p.m., the Associate Administrator</p>			

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	<p>indicated the Nurse Practitioner saw Resident B the following day after his fall and did not feel like the resident needed to be sent out because his neurological assessments were within normal limits. She indicated no notification of the family was found related to the start of the Lexapro on 5/1/15 or specific to the fall on 2/15/15. She indicated the nurse, who was working at the time of the fall, no longer worked at the facility.</p> <p>Review of a current facility policy, dated 1/14, titled "FALL RISK AND POST FALL ASSESSMENT", which was provided by the Director of Nursing (DON) on 6/25/15 at 4:35 p.m., indicated the following:</p> <p>"Purpose: It is the policy of Peabody Retirement Community to conduct appropriated assessments prior to and after falls.</p> <p>...PROCEDURE</p> <p>1. Licensed Nurse will conduct Fall Risk Assessment...</p> <p>...4. Licensed Nurse will conduct assessment of the resident.</p> <p>...f) If no major injury is suspected, assist resident to return to their room.</p> <p>g) Perform head to toe assessment in privacy of resident's room...</p> <p>h) Document assessment findings in</p>						

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	<p>nursing notes and make necessary notifications."</p> <p>A second undated policy titled "RESIDENT RIGHTS", which was provided by Associated Administrator on 6/25/15 at 9:15 a.m., indicated the following:</p> <p>BASIC RIGHTS</p> <ul style="list-style-type: none"> *You have the right to be treated with respect and dignity in recognition of your individuality and preferences. *You have the right to quality care and treatment that is fair and free of discrimination. *Relatives or a legal representative may act on your behalf to exercise these rights when you are unable to do so yourself. <p>"...Medical Care and Treatment: You have a right to:</p> <ul style="list-style-type: none"> *Participate in designing your plan of care/treatment. *Choose your personal doctor. *Refuse any plan of care, treatment or procedure. *Make advanced directives for treatment such as durable power of attorney for health care or other instructions about important health care decisions...." <p>This Federal tag relates to Complaint IN00176441.</p> 			

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F 0282 SS=D Bldg. 00	<p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure the Plan of Care was followed related to restorative services being provided for 3 of 4 residents whose Care Plans were reviewed in a sample of 4. (Residents B, C and D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 6/24/15 at 10:00 a.m. Diagnoses for Resident B included, but were not limited to, congestive heart failure, chronic airway obstruction, hypertension, aphasia and depression.</p> <p>Review of Resident B's current care plans indicated the following:</p> <p>"...has had declines in ability to ambulate."</p> <p>The goal for Resident B was to ambulate</p>	F 0282	<p>The filing of this plan of correction does not constitute an admission that the alleged deficiencies exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulation and continue to provide quality care. We respectfully request a desk review.</p> <ul style="list-style-type: none"> · The restorative care plans for Residents B, C, and D were reviewed and updated as needed. · The care plans were reviewed and updated as needed for all residents who have a restorative program. · Restorative staff received Care Plan Policy education on 7/10/15. · Restorative documentation will be reviewed daily by the DON/Designee on regular business days for 30 days, weekly for 3 months, monthly for 6 months, and ongoing thereafter until 100% of the threshold is achieved. The QAPI 	07/25/2015

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	<p>100 feet 6-7 days per week.</p> <p>Interventions included but were not limited to; "praise resident for participating with walking program, ensure resident has on nonskid footwear prior to ambulating...."</p> <p>Review of the Restorative Walking Report, provided by the Associate Administrator on 6/25/15 at 1:00 p.m., indicated the dates Resident B was provided restorative walking;</p> <p>March 3, 4, 14, 15, 16, 17, 18 and 19.</p> <p>April 1, 9, 14, 23, 24, 27, 28 and 29.</p> <p>May 4, 13, 19, 26, and 27.</p> <p>June 9, 11, 13, 14 and 15.</p> <p>No explanation was given as to why the resident had not received the restorative treatments.</p> <p>2. The clinical record for Resident C was reviewed on 6/24/15 at 11:00 a.m. Diagnoses for Resident C included, but were not limited to, dementia, depression, hypertension, anxiety and chronic kidney disease.</p> <p>Review of Resident C's current care plans</p>		<p>committee, chaired by the Administrator, will oversee compliance with the Director of Nursing/Designee having responsibility reporting. Systemic changes will be completed by July 25, 2015.</p>	

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	<p>indicated the following:</p> <p>"Impaired ability and safety in ambulation requires limited assistance resident is at risk for further declines in her ability due to disease process."</p> <p>The goal for Resident C was to ambulate 300 feet 6-7 days per week.</p> <p>Interventions included but were not limited to; "Ambulate with assistance of one, use gait belt and rolling walker...provide rolling walker for ambulation...ensure resident has on nonskid footwear prior to ambulation...."</p> <p>Review of the Restorative Walking Report, provided by the Associate Administrator on 6/25/15 at 1:00 p.m., indicated the dates Resident C was provided restorative walking;</p> <p>March 1, 2, 3, 4, 5 and 25.</p> <p>April-no restorative walking was provided.</p> <p>May 30 and 31.</p> <p>June 1, 2, 3, 4,</p> <p>No explanation was given as to why the resident was not walked.</p>				

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	<p>3. The clinical record for Resident D was reviewed on 6/24/15 at 11:35 a.m. Diagnoses for Resident D included, but were not limited to, congestive heart failure, anemia, hypertension, diabetes mellitus, neuropathy and paraplegia.</p> <p>Review of Resident D's current care plans indicated the following:</p> <p>"Limitations in range of motion ability related to dx [diagnosis] of paraplegia... has right hand contracture and bilat [bilateral] foot drop."</p> <p>The goal for Resident D was to participate in passive range of motion exercises for 2 sets of 25 reps [repetition] to bilat [bilateral] upper and lower extremities 6-7 days per week.</p> <p>Interventions included but were not limited to: "restorative nursing to reapproach resident later if he is refusing...monitor for s/s [signs and symptoms] of further declines or contractures...ensure when working with resident that right hand splint is still being utilized...."</p> <p>Review of the Restorative Passive Range of Motion (PROM) Report, provided by the Associate Administrator on 6/25/15 at</p>			

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	<p>1:00 p.m., indicated the dates Resident D was provided PROM;</p> <p>March 1, 3, 4, 5, 29 and 30.</p> <p>April 7, 8, 10, 16, 17, 20, 25, 27 and 30.</p> <p>May 1, 27, 30 and 31.</p> <p>June 1, 2, 3, 4, 10, 17, 19 and 20.</p> <p>No information was provided as to why the resident had not received the restorative treatments.</p> <p>During an interview on 6/25/15 at 2:41 p.m., the Associate Administrator indicated the facility had 4 staff that provided restorative services. She indicated they had all left for the day. She was unaware the services were not being provided as directed in the care plans.</p> <p>Review of a current facility policy, dated July 2014, titled "Care Plans-Comprehensive", which was provided by the Director of Nursing (DON) on 6/25/15 at 4:30 p.m., indicated the following:</p> <p>"Highlights Policy Statement An individualized comprehensive care plan that includes measurable objectives</p>				

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	<p>and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident.</p> <p>...1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain.</p> <p>...3. Each resident's comprehensive care plan is designed to:</p> <p>a. Incorporate identified problem areas;</p> <p>...c Build on resident's strengths;</p> <p>...e. Reflect treatment goals, timetables and objectives in measurable outcomes;</p> <p>f. Identify the professional services that are responsible for each element of care;</p> <p>g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels;...."</p> <p>This Federal tag relates to Complaint IN00176441.</p> <p>3.1-35(g)(2)</p>			