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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 11/18/2013 |
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| NAME OF PROVIDER OR SUPPLIER TIMBERVIEW HEALTH CARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00139143.</p> <p>Complaint IN00139143-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey dates: November 12, 13, 14, 15 and 18, 2013</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Cynthia Stramel, RN, TC Lara Richards, RN Regina Sanders, RN Jan Kulik, RN (11/12/13) Yolanda Love, RN (11/14, 11/15, 11/18, 2013)</p> <p>Census bed type: SNF: 6 SNF/NF: 113 Total: 119</p> <p>Census payor type: Medicare: 13</p> | F000000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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| | <p>Medicaid: 99 Other: 7 Total: 119</p> <p>These deficiencies reflect state finding cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 23, 2013, by Janelyn Kulik, RN.</p> | | | | |

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| F000156 SS=A | <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p> | | | | | | |

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| | <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p> | | | |

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| | <p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure notice of Non-Medicare coverage letters were provided in a timely manner for 2 of 3 residents reviewed for liability notices. (Residents #33 and #88)</p> <p>Findings include:</p> <p>1. Review of the Medicare Non-coverage letter for Resident #33 on 11/15/13 at 10:00 a.m., indicated the resident's Medicare services were going to end on 6/27/13. The letter was signed by the resident on 6/28/13.</p> <p>Interview with the Business Office Manager at the time, indicated the resident had received verbal notification on 6/25/13, but she did not indicate this on the form.</p> <p>2. Review of the Medicare Non-coverage letter for Resident #88 on 11/15/13 at 10:00 a.m., indicated the resident's Medicare services were going to end on 6/26/13. The letter was signed by the resident on 6/25/13.</p> <p>Interview with the Business Office</p> | F000156 | <p>F156 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Unable to correct deficiencies for Resident #33 and #88 2) How the facility identified other residents: Audit of Medicare Non-coverage letters sent in the last 30 days will be completed to identify any other residents affected. 3) Measures put into place/ System changes: Medicare Non-coverage letters will be reviewed weekly during Medicare meeting to ensure notices were given timely and dated correctly. The Business Office Manager or designee is responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13</p> | 12/16/2013 |

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| | <p>Manager at the time, indicated the resident had received verbal notification on 6/24/13, but she did not indicate this on the form.</p> <p>3.1-4(j)(2)</p> | | | |

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| F000241 SS=D | <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, record review and interview, the facility failed to ensure each residents' dignity was maintained during dining related to being called "honey" and "baby" for 1 of 1 meals observed on the Progressive Care Unit. (Resident #85)</p> <p>Findings include:</p> <p>On 11/12/13 at 12:13 p.m., in the Progressive Care Unit (PCU) dining room, Restorative Aide #2 was overheard calling Resident #85 "honey" and "baby."</p> <p>The record for Resident #85 was reviewed on 11/18/13 at 11:00 a.m. Review of the current plan of care, indicated the resident did not have a care plan indicating that he liked to be called "honey" and "baby."</p> <p>Interview with the Nurse Consultant on 11/18/13 at 11:53 a.m., indicated the resident should not have been called "honey" or "baby."</p> | F000241 | <p>F241 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified: Restorative aide #2 was re-educated regarding dignity and calling residents by preferred name. Resident #85 denied being upset or offended. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/ System changes: Staff will be re-educated regarding dignity and calling residents by their preferred name. Facility management will observe staff interaction with residents during meals and randomly during observation rounds at least 5x/week on varied shifts to ensure dignity is</p> | 12/16/2013 | |

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| | 3.1-3(t) | | maintained.Social Service Director or designee will be responsible for oversight of these audits. 4) How the corrective actions will be monitored:The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13 | | |

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| F000246 SS=D | <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation and interviews, the facility failed to ensure the resident's call lights were positioned so that the residents could reach them and call for assistance for 3 residents in a sample of 40. (Resident #179, #47, and #42)</p> <p>Findings include:</p> <p>1. Resident #179 was observed in bed on 11/13/13 at 8:12 a.m. The resident's call light was not within reach. The call light was lying on the floor.</p> <p>Interview with LPN #6 on 11/18/13 at 11:41 a.m., indicated the resident was alert, oriented to self, and unable to locate the call light due to vision impairment.</p> <p>2. On 11/12/13 at 11:04 a.m., Resident # 47 was observed seated in her wheelchair with her back to the bed. The resident's call light was not within reach. The call light was clipped to the resident's bed.</p> | F000246 | F246 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified: Facility ensured call lights for Residents #179, #47 and #42 were placed in reach upon notification. 2) How the facility identified other residents: Rounds were completed to ensure call lights were in reach for residents able to use call light. 3) Measures put into place/ System changes: Staff will be re-educated regarding placement of call lights within resident reach. Observation rounds will be completed at least 5x/week on varied shifts to ensure compliance. The Director of Nursing or designee will be | 12/16/2013 | | | |

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| | <p>Interview with LPN # 5 on 11/18/13 at 11:45 a.m., indicated the resident was alert, oriented to self, and capable of using the call light.</p> <p>3. Resident #42 was observed on 11/12/13 at 10:26 a.m. seated in her wheelchair. The resident's call light was not within reach. The call light was clipped to the resident's privacy curtain located on the opposite side of the resident.</p> <p>Interview with LPN #5 on 11/18/13 at 11:46 a.m., indicated the resident was alert, oriented, and capable of using the call light.</p> <p>3.1-19(u)(1)</p> | | <p>responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13</p> | | |

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| F000282 SS=D | <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to removal of facial hair for 1 of 3 residents reviewed for activities of daily living (ADL's) of the 5 who met the criteria for ADL's, as well as, ensuring anti-contracture devices were in place for 1 of 3 residents reviewed for range of motion (ROM) of the 8 who met the criteria for ROM. (Residents #6 and #62)</p> <p>Findings include:</p> <p>1. On 11/13/13 at 12:01 p.m., Resident #6 was observed with a growth of facial hair to her chin.</p> <p>On 11/14/13 at 1:25 p.m., the resident was observed in her room receiving care by facility staff.</p> <p>On 11/15/13 at 1:24 p.m., the resident was observed in her room in bed. The resident had a growth of facial hair to her chin.</p> | F000282 | F282 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified:Resident #6 – facial hair was removed.Resident #62 was referred to therapy for evaluation of contracture management.2) How the facility identified other residents:ADL rounds were completed to identify any other residents who needed facial hair removed.Audit was completed of all residents with orders for anti-contracture devices to ensure devices were applied as ordered. 3) Measures put into place/ System changes:Nursing staff will be re-educated regarding resident grooming and hygiene.Nursing staff will be re-educated regarding application of anti-contracture devices per | 12/16/2013 | | | |

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| | <p>On 11/18/13 at 10:27 a.m., the resident was observed in her room in bed. The resident had a growth of facial hair to chin.</p> <p>The record for Resident #6 was reviewed on 11/14/13 at 11:45 a.m. The resident's diagnoses included, but were not limited to, contracture of hand joint, contracture of upper arm joint, and muscular wasting and disuse atrophy.</p> <p>The plan of care dated 10/8/13, indicated the resident had an activity of daily living (ADL) self care performance deficit related to cerebrovascular accident (CVA/stroke).</p> <p>The interventions included, but were not limited to, offer choices with bathing and encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>Review of the ADL flow sheet indicated the resident had received personal hygiene care (how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands) on 11/12-11/18/13.</p> <p>Interview with the resident on</p> | | <p>physician orders and plan of care. ADL observation rounds will be completed at least 5x/week on varied shifts to ensure compliance. Observation rounds will be completed on at least 5 residents per week with anti-contracture devices to ensure compliance. The Director of Nursing will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13</p> | | |

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| | <p>11/15/13 at 1:24 p.m., indicated the aides help her get washed up. She indicated that she wished they would remove the hair on her chin.</p> <p>Interview with LPN #2 on 11/15/13 at 1:33 p.m., indicated the resident was dependent on staff for her ADL's.</p> <p>Interview with CNA #3 on 11/15/13 at 1:48 p.m., indicated the resident was dependent on staff for ADL's. She indicated that she shaves the resident when she will let her, she indicated the resident often refuses and says "I am not a man, I don't need to be shaved."</p> <p>Interview with LPN #3 on 11/18/13 at 10:30 a.m., indicated she would have the resident's facial hair removed.</p> <p>Interview with the Nurse Consultant on 11/18/13 at 12:45 p.m., indicated the resident had received ADL care on the above dates and the resident should have had her facial hair removed. She also indicated if the resident refused to have her facial hair removed, that it should have been documented and the Nursing staff notified.</p> | | | | | | |

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| | <p>2. Resident #62 was observed on 11/13/13 at 10:44 a.m., 3:39 p.m. and 11/14/13 at 9:39 a.m. lying in bed. The resident had contractures of both (bilateral) hands. The resident had no splints, braces, nor palm protectors on.</p> <p>During an observation on 11/14/13 at 1:15 p.m., with CNA #2 present, CNA #2 indicated the resident did not have palm protectors on, and there were no splints or braces on the resident's arms, hands, or legs. She indicated Restorative Nursing was suppose to put the splints, braces and palm protectors on the resident.</p> <p>Resident #62's record was reviewed on 11/14/13 at 9:39 a.m. The resident's diagnoses included, but were not limited to, contracture of upper arm and hand joint and joints of multiple sites and cerebral artery occlusion. The resident had been re-admitted into the facility from a hospital stay on 10/10/13.</p> <p>A care plan, initially dated 10/07/11, with a goal target date of 01/09/14, indicated the resident required splinting to both knees for contracture management. The interventions included, "apply splint in a.m., remove</p> | | | | | | |

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| | <p>p.m...perform rom (range of motion) to extremity for splint application."</p> <p>A care plan, initially dated 10/07/11, with a goal target date of 01/09/14, indicated the direct care staff were to apply right palm protectors and the resident was to have the palm protectors on at all times except during care. The interventions included to clean and dry hands, then apply the palm protectors.</p> <p>The Physician's orders indicated the following active orders, as of 11/13/13: 9/25/12- "Occupational Therapy Clarification: Bilateral hand and right elbow splint donn (sic) before breakfast and doff (sic) after lunch secondary to contracture management of the hand and right elbow." 07/20/13-"OT (Occupational Therapy) recommends use of right hand palm protector at all times except for hygiene needs." 01/07/13-"Clarification Orders from Skilled Occupational Therapy. Resident to wear at all times Bilateral Palm Protectors except for hygiene routine to assist with prevention of skin breakdown."</p> <p>During an interview on 11/14/13 at</p> | | | | | | |

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| | <p>1:20 p.m., Restorative CNA #3, indicated the CNA's working the unit were suppose to put the palm protectors on the resident. She indicated she did not know anything about the braces and/or splints for the resident.</p> <p>3.1-35(g)(2)</p> | | | |

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| F000312 SS=D | <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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> <p>Based on observation, record review and interview, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADL's) received assistance with removing facial hair for 1 of 3 residents reviewed for activities of daily living of the 5 who met the criteria for ADL's. (Resident #6)</p> <p>Findings include:</p> <p>On 11/13/13 at 12:01 p.m., Resident #6 was observed with a growth of facial hair to her chin.</p> <p>On 11/14/13 at 1:25 p.m., the resident was observed in her room receiving care by facility staff.</p> <p>On 11/15/13 at 1:24 p.m., the resident was observed in her room in bed. The resident had a growth of facial hair to her chin.</p> <p>On 11/18/13 at 10:27 a.m., the resident was observed in her room in bed. The resident had a growth of</p> | F000312 | <p>F312 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:Resident #6 – facial hair was removed. 2) How the facility identified other residents:ADL rounds were completed to identify any other residents who needed facial hair removed. 3) Measures put into place/ System changes:Nursing staff will be re-educated regarding resident grooming and hygiene.ADL observation rounds will be completed at least 5x/week on varied shifts to ensure compliance.The Director of Nursing will be responsible for oversight of these audits. 4) How the corrective actions will be monitored:The results of these</p> | 12/16/2013 | | | |

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| | <p>facial hair to chin.</p> <p>The record for Resident #6 was reviewed on 11/14/13 at 11:45 a.m. The resident's diagnoses included, but were not limited to, contracture of hand joint, contracture of upper arm joint, and muscular wasting and disuse atrophy.</p> <p>Review of the 10/14/13 Quarterly Minimum Data Set assessment (MDS), indicated the resident needed extensive assistance with personal hygiene.</p> <p>The plan of care dated 10/8/13, indicated the resident had an activity of daily living (ADL) self care performance deficit related to cerebrovascular accident (CVA/stroke).</p> <p>The interventions included, but were not limited to, offer choices with bathing and encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>Review of the ADL flow sheet indicated the resident had received personal hygiene care (how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying</p> | | <p>audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13</p> | | |

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| | <p>face and hands) on 11/12-11/18/13.</p> <p>Interview with the resident on 11/15/13 at 1:24 p.m., indicated the aides help her get washed up. She indicated that she wished they would remove the hair on her chin.</p> <p>Interview with LPN #2 on 11/15/13 at 1:33 p.m., indicated the resident was dependent on staff for her ADL's.</p> <p>Interview with CNA #3 on 11/15/13 at 1:48 p.m., indicated the resident was dependent on staff for ADL's. She indicated that she shaves the resident when she will let her, she indicated the resident often refuses and says "I am not a man, I don't need to be shaved."</p> <p>Interview with LPN #3 on 11/18/13 at 10:30 a.m., indicated she would have the resident's facial hair removed.</p> <p>Interview with the Nurse Consultant on 11/18/13 at 12:45 p.m., indicated the resident had received ADL care on the above dates and the resident should have had her facial hair removed. She also indicated if the resident refused to have her facial hair removed, that it should have been documented and the Nursing staff notified.</p> | | | | | | |

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| | 3.1-38(a)(3)(D) | | | |

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| F000318 SS=D | <p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a 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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident received appropriate treatment for contractures to prevent further decrease in range of motion, for 1 of 3 residents reviewed out of 8 who met the requirement for range of motion. (Resident #62)</p> <p>Findings include:</p> <p>Resident #62 was observed on 11/13/13 at 10:44 a.m., 3:39 p.m. and 11/14/13 at 9:39 a.m. lying in bed. The resident had contractures of both (bilateral) hands. The resident had no splints, braces, or palm protectors on.</p> <p>During an observation on 11/14/13 at 1:15 p.m., with CNA #2 present, CNA #2 indicated the resident did not have palm protectors on, and there were no splints or braces on the resident's arms, hands, or legs. She indicated</p> | F000318 | <p>F318 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:Resident #62 was referred to therapy for evaluation of contracture management. 2) How the facility identified other residents:Audit was completed of all residents with orders for anti-contracture devices to ensure devices were applied as ordered. 3) Measures put into place/ System changes:Nursing staff will be re-educated regarding application of anti-contracture devices per physician orders and plan of care.Observation rounds will be completed on at least 5 residents per week with anti-contracture</p> | 12/16/2013 | | | |

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| | <p>Restorative Nursing was suppose to put the splints, braces and palm protectors on the resident.</p> <p>Resident #62's record was reviewed on 11/14/13 at 9:39 a.m. The resident's diagnoses included, but were not limited to, contracture of upper arm and hand joint and joints of multiple sites and cerebral artery occlusion. The resident had been re-admitted into the facility from a hospital stay on 10/10/13.</p> <p>A Quarterly MDS assessment, dated 10/17/13, indicated the resident required extensive assistance for activities of daily living and had impaired movement of both upper and lower extremities.</p> <p>A care plan, initially dated 10/07/11, with a goal target date of 01/09/14, indicated the resident required splinting to both knees for contracture management. The interventions included, "apply splint in a.m., remove p.m...perform rom (range of motion) to extremity for splint application."</p> <p>A care plan, initially dated 10/07/11, with a goal target date of 01/09/14, indicated the direct care staff were to apply right palm protectors and the resident was to have the palm</p> | | <p>devices to ensure compliance. The Director of Nursing will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13</p> | |

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| | <p>protectors on at all times except during care. The interventions included to clean and dry hand then apply the palm protectors.</p> <p>The Physician's orders indicated the following active orders, as of 11/13/13: 9/25/12- "Occupational Therapy Clarification: Bilateral hand and right elbow splint donn (sic) before breakfast and doff (sic) after lunch secondary to contracture management of the hand and right elbow." 07/20/13-"OT (Occupational Therapy) recommends use of right hand palm protector at all times except for hygiene needs." 01/07/13-"Clarification Orders from Skilled Occupational Therapy. Resident to wear at all times Bilateral Palm Protectors except for hygiene routine to assist with prevention of skin breakdown."</p> <p>During an interview on 11/14/13 at 1:20 p.m., the Minimum Data Set (MDS) Nurse/Restorative Nurse indicated the CNA's on the unit were suppose to apply the palm protectors and she would check about the braces.</p> <p>During an interview on 11/14/13 at</p> | | | | | | |

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| | <p>1:25 p.m., LPN #1 indicated she could not find where the palm protectors had been documented they were applied. She indicated there was an active order for the palm protectors. She indicated Restorative Nursing had not restarted the resident on restorative rehabilitation since the resident had returned from the hospital because therapy had said they were not going to treat the resident. She indicated therapy was going to re-evaluate the resident today.</p> <p>During an interview on 11/14/13 at 3:00 p.m., the Corporate Nurse Consultant indicated she had discontinued the brace on Monday (11/11/13) because the resident had not been wearing the splint. She indicated the Nurse had just (11/14/13) discontinued the order for palm protectors. She indicated the physician's order for the knee brace was still an active order.</p> <p>During an interview on 11/15/13 at 11:50 am., The Director of Therapy indicated a new evaluation had been completed on the resident and the palm protectors and splints were still needed.</p> <p>An Occupational Therapy note, dated</p> | | | |

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| | <p>10/11/13, indicated, "...Current Reason for Referral: Patient was admitted to the hospital and now returns to the facility with OT (Occupational Therapy) orders to evaluate and treat...UE (upper extremity) ROM (Range of Motion). RUE (right upper extremity)=Impaired (Impaired shoulder, elbow wrist and hand PROM [passive range of motion]); LUE (left upper extremity) ROM=[impaired (Impaired shoulder, elbow wrist and hand PROM.)...Clinical Impressions: Patient does not appear to demonstrate need for skilled OT intervention. Patient has not demonstrated a decline in functional independence, positioning, PROM, or activity tolerance...Patient does not demonstrate any potential to increase her functional independence with self care tasks."</p> <p>A Physical Therapy (PT) evaluation, dated 10/11/13, indicated, "...Clinical Impressions: Poor rehab potential. Skilled services not indicated at this time...Assessment Summary...Risk Factors: Further contractures..."</p> <p>A OT evaluation and Plan of Treatment, dated 11/15/13, indicated, "...Plan of Treatment. Short-Term Goals #1.0 Patient will tolerate use of</p> | | | | |

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| | <p>bilateral palm protectors at all times except during hygiene or bathing tasks to promote healthy skin integrity, decrease risk of skin breakdown, and to promote patient comfort...#2.0 Patient will tolerate use of right elbow splint up to 1 hour without signs of discomfort or decreased skin integrity (sic)...Reason for Referral: Patient demonstrates a need for skilled OT intervention to assess current functional positioning needs for BUE (bilateral upper extremities)...Clinical Impressions: Patient clearly demonstrates need for skilled OT intervention as patient UB (upper body) functional positioning should be addressed due to patient need for use of right elbow splint, bilateral palm protectors..."</p> <p>3.1-42(a)(2)</p> | | | |

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| F000431 SS=D | <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure medications were stored and disposed of properly related to insulin</p> | F000431 | F431 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or | 12/16/2013 | | | |

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| | <p>storage and returning discontinued medication on 2 of 3 units throughout the facility. (The North and South units)</p> <p>Findings include:</p> <p>1. On 11/14/13 at 4:24 p.m., LPN #4 was observed administering medications on the South unit. The LPN entered Room 224 and went behind the privacy curtain. A plastic tray containing 13 vials of insulin was left on top of the medication cart. The cart was not in view of the LPN while she was in the resident's room.</p> <p>After leaving the room, the LPN went down the hall to wash her hands. The tray of insulin was left on top of the medication cart and out of the LPN's view. The House Supervisor instructed the LPN that she could not leave the insulin on top of the medication cart.</p> <p>Interview with the House Supervisor on 11/18/13 at 11:00 a.m., indicated the tray of insulin should not have been left on the top of the medication cart out of the LPN's site.</p> <p>2. The North unit medication room</p> | | <p>execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified: Insulin vials were placed in secured area. Expired medications were disposed of / destroyed per policy. How the facility identified other residents: Rounds were completed to ensure no other medications were improperly stored or needed to be disposed of or sent back to pharmacy. 3) Measures put into place/ System changes: Licensed staff will be re-educated regarding storage and disposal of medications. Audit of medication carts and refrigerators will be completed at least 2x/week and during random observation rounds on varied shifts to ensure medications are properly stored and disposed of in a timely manner. The Director of Nursing or designee will be responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13</p> | | |

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| | <p>was observed on 11/15/13 at 1:50 p.m. In the medication refrigerator was a locked box containing expired medications. Haldol 2 mg (milligrams)/5 ml (milliliters), Lorazepam 2 mg/5 ml, and Morphine sulfate 20 mg/5 ml.</p> <p>Interview with the Unit Manager at that time indicated the medications should have been disposed of when the resident expired.</p> <p>3.1-25(m) 3.1-25(o)</p> | | | | |

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| F000441 SS=D | <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview the facility failed to maintain infection</p> | F000441 | F441 The facility requests paper compliance for this citation. This | 12/16/2013 | | | |

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| | <p>control related to the storage of residents' toothbrushes being stored uncovered on the back of sinks and commodes, for 5 residents in a sample of 40. (Resident #47, #51, #48, #14, and #179)</p> <p>Findings include:</p> <p>1. On 11/12/13 at 11:04 a.m., Resident #47's restroom was observed. A toothbrush was observed stored on the sink uncovered.</p> <p>On 11/18/13 at 11:19 a.m., Resident #47's restroom was observed. A toothbrush was observed in a container uncovered on the back of the commode.</p> <p>2. On 11/13/13 at 8:00 a.m., Resident #51's restroom was observed. A toothbrush was observed stored uncovered on the back of the commode.</p> <p>On 11/18/13 at 11:21 a.m., Resident #51's restroom was observed. A toothbrush was observed in a container uncovered on the back of the commode.</p> <p>3. On 11/13/13 at 8:00 a.m., Resident #48's restroom was observed. A toothbrush was</p> | | <p>Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified: Toothbrushes for Residents #47, #51, #48, #14 and #179 were replaced and placed in container in bedside drawer. 2) How the facility identified other residents: Rounds were completed and toothbrushes were replaced and properly stored as identified. 3) Measures put into place/ System changes: Nursing staff will be re-educated regarding proper storage of toothbrushes. Observation rounds will be completed at least 5x/week on varied shifts to ensure compliance. The Director of Nursing will be responsible for oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13</p> | | |

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| | <p>observed stored uncovered on the back of the commode.</p> <p>On 11/18/13 at 11:21 a.m., Resident #48's restroom was observed. A toothbrush was observed in a container uncovered on the back of the commode.</p> <p>4. On 11/13/13 at 10:18 a.m., Resident #14's restroom was observed. A toothbrush was observed stored uncovered on the back of the commode.</p> <p>On 11/18/13 at 11:23 a.m., Resident #14's restroom was observed. A toothbrush was observed in a container uncovered on the back of the commode.</p> <p>5. On 11/12/13 at 8:12 a.m., Resident #179's restroom was observed. A toothbrush was observed stored uncovered on the back of the commode next to a urinal.</p> <p>On 11/18/13 at 11:34 a.m., Resident #179's restroom was observed. A toothbrush was observed in a container uncovered on the back of the commode.</p> <p>Interview with Housekeeper #1 on 11/18/13 at 11:36 a.m., indicated</p> | | | |

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| | <p>when cleaning the resident's restrooms the items stored on the back of the commodes are removed, discarded and replaced.</p> <p>Interview with the Administrator on 11/18/13 at 3:20 p.m., indicated the resident's toiletries may be stored in their top dresser drawer.</p> <p>3.1-18(j)</p> | | | |

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| F000463 SS=D | <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents were provided functioning call system devices at their bedsides, for 2 residents in a sample of 40. (Resident #80 and #96)</p> <p>Findings include:</p> <p>On 11/12/13 at 2:35 p.m., an observation was made in Room 202. The call lights were missing for Residents #80 and #96 who resided in that room.</p> <p>Resident #80's record was reviewed on 11/14/13 at 9:30 a.m. Diagnoses included dementia and depression. MDS quarterly assessment dated 10/14/13 indicated BIMS (Brief Interview for Mental Status) score of 05, indicating severe cognitive impairment. Functional status indicated resident was able to walk in room and corridor with supervision and one person physical assistance.</p> <p>Resident #96's record was reviewed</p> | F000463 | <p>F463 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Immediate actions taken for those residents identified:Call light cord for residents #80 and #96 was replaced. 2) How the facility identified other residents:Rounds were completed to ensure call light cords were present and functioning in all resident rooms.No further issues were identified. 3) Measures put into place/ System changes:Facility staff will be re-educated to notify maintenance immediately if call light cords are missing or if call lights are not functioning.Observation rounds will be completed at least 5x/week on varied shifts to ensure compliance.The Administrator is responsible for</p> | 12/16/2013 | | | |

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| | <p>on 11/14/13 at 9:16 a.m. Diagnoses included dementia, depression, seizure disorder and cancer. Significant change MDS dated 10/2/13 indicated BIMS (Brief Interview for Mental Status) score of 04, indicating severe cognitive impairment. Functional status indicated resident was able to walk in corridor with supervision and one person physical assistance.</p> <p>Interview with CNA #1 at that time indicated Resident #96 would sometimes pull the call light out. She was aware the call light was missing and indicated she reported it to the maintenance department and they would be replacing it today.</p> <p>Interview with LPN #1 at that time indicated she was unaware the call lights were missing, she then notified the maintenance department.</p> <p>Interview with Maintenance Man #1 on 11/12/13 at approximately 3:30 p.m., indicated he was not aware the call lights in Room 202 were missing. Further interview with CNA #1 indicated she had told Maintenance Man #2 on 11/12/13 about the missing call light.</p> <p>Interview with Maintenance Man #2</p> | | <p>oversight. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 12/16/13</p> | | |

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| | <p>on 11/18/13 at 9:00 a.m., indicated he did not recall a report related to missing call lights, but would check the maintenance department logs. At 9:40 a.m., Maintenance Man #2 found a repair slip dated 11/12/13, initialed RH.</p> <p>3.1-19(u)(1)</p> | | | |