

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2016
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 6, 7, 8, 9, 10 & 13, 2016</p> <p>Facility number: 000034 Provider number: 155086 AIM number: 100274880</p> <p>Census bed type: SNF/NF: 56 Total: 56</p> <p>Census payor type: Medicare: 3 Medicaid: 51 Other: 2 Total: 56</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 14454 on June 17, 2016.</p>	F 0000	<p>Survey Event ID: 7R7111 Exit Date: 06.13.2016</p> <p>Please consider this Plan of Correction as the facility's credible allegation of compliance. This Plan of Correction constitutes a written allegation of substantial compliance under Federal Medicare requirements. Submission of this Plan of Correction is not admission that a deficiency exists or that the facility agrees they were cited correctly. This Plan of Correction reflects a desire to continuously enhance the quality of care and services provided to our residents and it is submitted solely as a requirement of the provisions of Federal and State law. If there are any further questions or concerns, please feel free to contact me at 574-295-0096. Respectfully, Kevin Baker, HFA</p> <p>Given the low degree of scope and severity of this survey, Woodland Manor respectfully request paper compliance.</p>	
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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 0246 SS=D Bldg. 00	<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.</p> <p>Based on observations, record review and interview, the facility failed to ensure 1 of 30 residents observed for call lights had a call light within their reach. (Resident #19)</p> <p>Finding includes: On 6/7/16 at 10:31 A.M., Resident #19</p>	F 0246	<p>In response to state findings regarding F 246:</p> <p>Element One: Resident #19's call light was repositioned and verified by return demonstration that resident was able to access her light.</p> <p>Element Two: All current in-house residents were assessed for call light access. No further concerns were</p>	07/10/2016

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	<p>was observed trying to reach for her call light, however the call light was out of the resident's reach. CNA (Certified Nursing Assistant) #1 indicated the call light was out of reach for the resident.</p> <p>During an environmental tour, on 6/13/16 from 1:20 P.M. thru 2:05 P.M., accompanied by the Maintenance Director and the Administrator the following was observed: Resident #19 was observed in bed with her call light clipped on top of her blanket. The resident was observed trying to get to her call light but was unable to bring her hands up over the blanket and verbalized she was unable to reach her call light.</p> <p>On 6/13/16 at 2:15 P.M., the clinical record for Resident #19 indicated the resident's diagnosis was multiple sclerosis.</p> <p>On 6/13/16 at 2:55 P.M., the Administrator provided the policy titled, "Call Lights," dated 5/2013 and indicated this was the one currently used by the facility. The policy indicated the purpose of the call light was "...To assure each resident will have a readily accessible means to obtain needed assistance...."</p> <p>3.1-3 (v)(1)</p>		<p>noted as of 6-21-16.</p> <p>Element Three: All current staff will be in-serviced regarding the current call light policy as of July 8, 2016</p> <p>Element Four: DON/designee will perform random audits for resident call light access five times per week for four weeks, then twice a week for four weeks, then weekly for four weeks. If audit shows 100% compliance, audit will be discontinued. Random nursing rounds will continue after audits are discontinued. Results of audit will be submitted to Quality Assurance Committee for review, any negative outcomes may result in additional action plans to achieve compliance.</p> <p>Woodland Manor maintains that complete compliance will be achieved by July 10, 2016.</p>		

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F 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interviews, the facility failed to</p>	F 0272	In response to state findings regarding F 272:	07/10/2016

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	<p>thoroughly assess 2 of 2 residents reviewed for urinary incontinence. (Resident #66 and Resident #63)</p> <p>Findings include:</p> <p>1. On 6/9/16 at 11:05 A.M., a review of the clinical record for Resident # 66 was conducted. The record indicated Resident #66 was admitted on 12/30/15 The resident's diagnoses included, but were not limited to: cerebrovascular accident with left nondominant hemiparesis, hypertension, gastroesophageal reflux disorder, dysphagia and coronary artery disease.</p> <p>An Admission Nursing Assessment, dated 12/31/16, indicated the resident was continent of bowel and bladder and used a urinal.</p> <p>The Nurse's Notes, dated 12/31/16 at 2:00 P.M., indicated the resident was continent with episodes of incontinence.</p> <p>The ADL (Activities of Daily Living) Grid (a form used to document voiding patterns) for 12/2015 was left blank. The ADL Grids for subsequent months were undated.</p> <p>An Admission Minimum Data Set (MDS), dated 1/6/16, indicated the</p>		<p>Element One: Residents 63 and 66 were assessed for current urinary continence status.</p> <p>Element Two: All residents were assessed for current urinary continence status.</p> <p>Element Three: All licensed nursing staff will be in-serviced regarding incontinence assessments and current policy related to bladder programming by July 8, 2016.</p> <p>Element Four: DON/MDS/Designee will review residents upon admission and at each MDS review to obtain baseline continence status and monitor for changes in continence status. Review will be weekly for 12 weeks and PRN with new admissions and per the current MDS assessment period. If Audit shows 100% compliance, audit will discontinued. Results of audit will be submitted to Quality Assurance Committee for review, any negative outcomes may result in additional action plans to achieve compliance.</p> <p>Woodland Manor maintains that complete compliance will be achieved by July 10, 2016.</p>	

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	<p>resident was occasionally incontinent. The Quarterly MDS assessment, dated 4/6/16, indicated the resident was frequently incontinent. The assessments indicated a toileting program had not been attempted with the Admission assessment or when the resident had an incontinence decline noted on the Quarterly assessment.</p> <p>During an interview, on 6/9/16 at 2:05 P.M., the MDS Consultant indicated when the facility went to computer charting in February 2016, the paper 3 day voiding pattern assessment form was no longer used by the facility. The staff was told to document in the computer under Urinary Continence Tracking Tool. Staff were informed to document time and if resident was continent or incontinent. Prior to going on the computer the facility used the ADL Grid to document episodes of incontinence. The MDS Consultant could not explain the look back period for the admission assessment due to no dates had been documented on the forms. The MDS Consultant could not find a 3 day voiding pattern assessment completed for the resident upon admission. The MDS Consultant indicated when the resident had a change from occasionally incontinent, on the MDS Admission Assessment, to frequently incontinent on</p>			

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	<p>the Quarterly MDS Assessment, there was no 3-day bladder assessment completed. The resident was never on a restorative plan to encourage or maintain a higher level of continent episodes. She indicated the facility realized there was a problem and have developed a new way to assess a resident's incontinence.</p> <p>On 6/9/16 at 3:25 P.M., the Nurse Consultant provided a policy titled "Assessing the Resident With Incontinence," dated 8/2009, and indicated the policy was the one currently used by the facility. The policy indicated "... 2. Complete an accurate, thorough assessment of factors that may predispose the resident. 3. ...When completing the comprehensive assessment, consider the following: Voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream) and, for those already experiencing urinary incontinence, voiding patterns over several days..."</p> <p>2. On 6/9/16 at 10:51 A.M., the clinical record was reviewed for Resident #63. Resident #63 was admitted to the facility on 12/21/15 with diagnoses, including but not limited to: arthritis, anxiety, Alzheimer's disease, spinal stenosis and chronic kidney disease Stage 3.</p> <p>A nursing admission assessment, dated</p>			

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	<p>12/21/15, indicated the resident was incontinent of urine due to risk factors of dementia and a history of incontinence. The bottom of the admission assessment form indicated if incontinent, complete a 3 day bladder tracking. There was no 3 day bladder tracking located on the paper or electronic charting.</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 12/28/15, indicated the resident was severely cognitively impaired, and required supervision for transfers and toilet use. The resident was documented as always continent of bowel and bladder and did not require a urinary toileting program.</p> <p>The quarterly MDS assessment, completed on 4/20/16, indicated the resident was severely cognitively impaired, required extensive two person assist with transfers and toilet use. The resident was documented as frequently incontinent and did not require a toileting program. A bowel and bladder assessment could not be located on the paper or electronic charting for Resident #63.</p> <p>During an interview, on 6/10/16 at 9:47 A.M., CNA (Certified Nursing Assistant) #22 indicated Resident #63 was incontinent and wears a brief. She</p>			

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	<p>indicated the resident can be combative with care at times so they just do the best they can. CNA#22 indicated the resident is unable to tell the staff when she needs to go so the staff just check her.</p> <p>During an interview, on 6/10/16 at 12:02 P.M., LPN (Licensed Practical Nurse) #23 indicated when the resident was first admitted she was continent but she has had a decline and is incontinent now and should be checked and changed every 2 hours by staff.</p> <p>During an interview, on 6/10/16 at 2:30 P.M., the Corporate MDS Coordinator indicated a bladder assessment should have been completed when the resident had a decline in her continence.</p> <p>On 6/10/16 at 3:25 P.M., the Corporate Nurse Consultant provided a policy titled "Continence Assessment," dated 05/2013 with no revision date, and indicated the policy was the one currently used by the facility. The policy indicated "...Each resident's continence will be assessed no less often than quarterly to assure proper provision of care...1. The Bowel and Bladder monitoring record will be initiated upon admission and during the assessment reference period for all subsequently scheduled MDS assessments. 2. The Bowel and Bladder</p>			

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F 0280 SS=D Bldg. 00	<p>monitoring record will be completed for 72 consecutive hours. 3. The continence care plan will be based on the resident's comprehensive assessment including but not limited to the Bowel and Bladder monitoring period...5. The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status...."</p> <p>3.1-31(d)(3)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal</p>			

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	<p>representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 3 families were invited to care plan meetings. (Resident #57)</p> <p>Finding includes:</p> <p>The clinical record for Resident #57 was reviewed on 06/09/2016 at 1:50 P.M. Resident #57 was admitted to the facility, on 04/21/14, with diagnoses, including but not limited to: Alzheimer's disease, osteoporosis, arteriosclerotic heart disease, fibromyalgia, asthma, inflammatory polyneuropathy, gastro esophageal reflux disease and hypertension.</p> <p>During an interview on 06/08/16 at 2:07 P.M., Resident's #57's family and Power of Attorney (POA) indicated that she had been invited to a care plan meeting and had attended but it had been "quite some time" since she had been invited.</p> <p>During an interview on 06/09/16 at 2:00 P.M., the Social Service Director (SSD) indicated the previous dementia unit director would have been responsible for inviting and documenting the invitation to care plan meetings for Resident #57.</p>	F 0280	<p>In response to state findings regarding F 280:</p> <p>Element One: Family member of resident #57 was invited (6-19-16) and attended a care conference (6-14-16) at 10am.</p> <p>Element Two: Current Care Plan schedule was reviewed and family/POA invitations were confirmed.</p> <p>Element Three: Admin/DON/SS/MDS/Activites/ADON and Program Director will be in-serviced on the current policy regarding care plan participation by 6-27-16.</p> <p>Element Four: SS/Designee will review upcoming MDS/Care Plan schedule each Monday (or start of the work week) for the following week and confirm that invitations have been sent/phoned to each responsible party to be involved in the care conference. All invitations shall be documented in the medical record. Invitation process will be audited weekly for 12 weeks. If audit shows 100% compliance audit will be discontinued. Results of audit will be submitted to Quality Assurance Committee for review, any negative outcomes may result in additional action plans to achieve compliance.</p>	07/10/2016

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F 0309 SS=D Bldg. 00	<p>The SSD indicated the last invitation to a care plan meeting she could locate for Resident #57's POA was signed and returned by Resident #57's POA on 01/30/15. The meeting had been scheduled for 02/03/15, and Resident #57's POA did attend the meeting. There was no documentation Resident #57's POA had been invited to care plan meetings since 02/03/15.</p> <p>3.1-35(c)(2)(C)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation and record review, the facility failed to ensure 1 of 3 nurse's observed passing medications followed the facility's policy and procedure regarding insulin administration for 1 of 2 residents observed receiving a rapid acting insulin. (Resident #27)</p>	F 0309	<p>Woodland Manor maintains that complete compliance will be achieved by July 10, 2016.</p> <p>In response to state findings regarding F 309:</p> <p>Element One: Resident #27 was observed in the dining room eating lunch and had no ill effects from receiving her Humalog (rapid acting) insulin 39 minutes prior to consuming a substantial beverage/meal.</p>	07/10/2016

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	<p>Finding includes:</p> <p>During a medication administration pass observation on 06/09/16 at 11:06 A.M., LPN (Licensed Practical Nurse) #25 was observed to administer 5 units of Humalog (rapid acting insulin) via a subcutaneous injection to Resident #27. LPN #25 then directed the resident to get herself around, brush her hair and head to the dining room for the noon meal. Resident #27 was observed to be in her room until 11:30 A.M. At 11:30 A.M., she ambulated to the dining room. At 11:45 A.M., the resident was drinking a cup of coffee with diabetic sweeteners in the coffee. She was not given any food or substantial drink after being administered the insulin injection.</p> <p>On 6/13/16 at 3:30 P.M., The facility Nurse Consultant, Employee #26 provided the facility policy, titled "Diabetes Mellitus - Routine Care," undated, and indicated this was the one currently used by the facility. The policy indicated "...Insulin needs to be given 30 minutes before the scheduled meal unless specifically ordered otherwise by the physician. Humalog insulin must be given within 15 minutes of a scheduled meal or given with food...."</p> <p>3.1-37(a)</p>		<p>Element Two: All residents receiving Humalog insulin were assessed and no concerns were noted.</p> <p>Element Three: All licensed nursing staff will be in-serviced on the standard nursing practice for administering rapid acting insulin by June 30, 2016</p> <p>Element Four: DON/designee will conduct random audits of insulin administration 5 times per week for 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks. If audit shows 100% compliance, audit will be discontinued. Results of audit will be submitted to Quality Assurance Committee for review, any negative outcomes may result in additional action plans to achieve compliance.</p> <p>Woodland Manor maintains that complete compliance will be achieved by July 10, 2016.</p>		

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F 0315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observations, record reviews and interviews, the facility failed to accurately and ensure interventions were provided to restore bladder function for 2 of 2 residents reviewed for incontinence decline. (Resident #66 and Resident #63)</p> <p>Findings include:</p> <p>1. On 6/9/16 at 11:05 A.M., a review of the clinical record for Resident # 66 was conducted. The record indicated the resident was admitted to the facility on 12/30/15. The resident's diagnoses included, but were not limited to: cerebrovascular accident (CVA) with left nondominant hemiparesis, hypertension, gastroesophageal reflux disorder,</p>	F 0315	<p>In response to state findings regarding F 315:</p> <p>Element One: Resident 63 and 66 were assessed for current bladder functioning status.</p> <p>Element Two: Residents who have experienced a decline in continence were assessed for a current voiding pattern and corresponding care plan as of June 30, 2016.</p> <p>Element Three: All licensed staff will be in-serviced regarding the current continence diary policy by June 30, 2016.</p> <p>Element Four: DON/MDS/designee will review resident's continence status according to their current MDS assessment period and create</p>	07/10/2016

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	<p>dysphagia and coronary artery disease.</p> <p>A pre-admission "Functional Status" form, undated, indicated the resident was incontinent of urine.</p> <p>An Admission Nursing Assessment, dated 12/31/16, indicated the resident was continent of bowel and bladder and used a urinal.</p> <p>Nurse's Notes, dated 12/31/16 at 2:00 P.M., indicated the resident was continent with episodes of incontinence.</p> <p>The ADL (Activities of Daily Living) Grid (a form used to document voiding patterns) for 12/2015 was left blank. The ADL Grids for subsequent months were undated.</p> <p>An Admission Minimum Data Set (MDS), dated 1/6/16, indicated the resident was occasionally incontinent of bladder had declined. The assessment indicated a toileting program had not been attempted.</p> <p>A careplan, dated 1/11/16, indicated the resident had an ADL-self care performance deficit related to a stroke. The interventions included but were not limited to: praise all efforts of self care and resident requires one staff</p>		<p>or update current care plans weekly and PRN as identified for 12 weeks. If audit shows 100% compliance, audit will be discontinued. Results of audit will be submitted to Quality Assurance Committee for review, any negative outcomes may result in additional action plans to achieve compliance.</p> <p>Woodland Manor maintains that complete compliance will be achieved by July 10, 2016.</p>				

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	<p>participation to use the toilet. An incontinence careplan, dated 1/11/16, indicated the resident had occasional incontinence related to limited mobility due to CVA with hemiparesis. Interventions included but were not limited to: assist resident as needed with toileting, observe skin and peri care per facility policy.</p> <p>The Quarterly MDS assessment, dated 4/6/16, indicated the resident was frequently incontinent. A Urinary Continence Tracking form, printed from the electronic chart, dated 3/31/16 thru 4/6/16, indicated during the 7 day look back period, the resident experienced incontinence each of the 7 days. There were 13 episodes of incontinence documented over the 7 day period. The assessment indicated a toileting program had not been attempted when the resident had an incontinence decline noted on the Quarterly assessment.</p> <p>During an interview, on 6/9/16 at 2:05 P.M., the MDS Consultant indicated when the facility went to computerized charting in February 2016, the paper 3 day voiding pattern assessment form was no longer utilized by the facility. The staff were told to document in the computer under Urinary Continence Tracking Tool. Staff were informed to</p>			

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	<p>document the time and if resident was continent or incontinent. Prior to going on the computer, the facility used the ADL Grid to document episodes of incontinence. The MDS Consultant could not determine the look back period for the admission assessment due to no dates being documented on the forms. The MDS Consultant could not find a 3 day voiding pattern assessment completed for the resident upon admission. The MDS Consultant indicated when the resident had a change from occasionally incontinent on the MDS Admission Assessment, to frequently incontinent on the Quarterly MDS Assessment, there had not been a 3-day bladder assessment completed. The MDS Consultant indicated the resident was never on a restorative plan to encourage or maintain a higher level of continent episodes.</p> <p>On 6/9/16 at 3:25 P.M., the Nurse Consultant provided a policy titled "Assessing the Resident With Incontinence," dated 8/2009, and indicated the policy was the one currently used by the facility. The policy indicated "...The first steps toward assuring that a resident receives appropriate treatment and services to restore as much bladder function as possible, or to treat and manage the incontinence are to: 1. Identify the resident already experiencing</p>			

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	<p>some level of incontinence or at risk of developing urinary incontinence. 2. Complete an accurate, thorough assessment of factors that may predispose the resident. 3. Implement appropriate, individualized interventions that address the incontinence including the resident's capabilities and underlying factors that can be removed, modified or stabilized...."</p> <p>2. On 6/9/16 at 10:51 A.M., the clinical record was reviewed for Resident #63. Resident #63 was admitted to the facility, on 12/21/15, with diagnoses, including but not limited to: arthritis, anxiety, Alzheimer's disease, spinal stenosis and chronic kidney disease Stage 3.</p> <p>A nursing admission assessment, dated 12/21/15, indicated the resident was incontinent of urine due to risk factors of dementia and a history of incontinence. The bottom of the admission assessment form indicated if incontinent, complete a 3 day bladder tracking. There was no 3 day bladder tracking located on the paper or electronic charting.</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 12/28/15, indicated the resident was severely cognitively impaired, and required supervision for transfers and toilet use.</p>			

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	<p>The resident was documented as always continent of bowel and bladder and did not require a urinary toileting program.</p> <p>A care plan, dated 12/30/15, indicated the resident had an ADL (Activities of Daily Living) deficit related to dementia and Alzheimer's. The interventions included, but were not limited to: Toilet Use: the resident requires one staff participation to use toilet. There was no care plan for incontinence located on the paper or electronic charting.</p> <p>The quarterly MDS assessment, completed on 4/20/16, indicated the resident was severely cognitively impaired, required extensive two person assist with transfers and toilet use. The resident was documented as frequently incontinent and did not require a toileting program. A bowel and bladder assessment could not be located on the paper or electronic charting for Resident #63.</p> <p>A Kardex Report, dated 6/10/16, indicated Toilet Use: The resident requires one staff participation to use toilet, uses toilet riser.</p> <p>On 6/9/16 at 10:45 A.M., Resident #63 was observed seated in her wheelchair in her room watching the television. The</p>			

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	<p>resident indicated she was tired and wanted to sit in the recliner. At 11:00 A.M., the resident was transferred with the assist of a CNA (Certified Nursing Assistant) and a nurse into her recliner. The resident had a strong urine odor noted when the resident was transferred. The resident was not checked or changed and was not offered to be toileted by the staff at this time. At 11:33 A.M., the resident was transferred from her recliner into her wheelchair with the assist of a nurse and CNA. The resident was not checked or changed and was not offered to be toileted by the staff. At 11:35 A.M., Resident #63 was transferred in her wheelchair by her husband and then to the dining room for her lunch.</p> <p>On 6/10/16 at 8:30 A.M.to 9:40 A.M., Resident #63 was observed resting in her bed with a hospital gown and a brief on.</p> <p>On 6/10/16 at 9:41 A.M., CNA #22 entered resident #63's room and indicated to the resident it was time for her bed bath. CNA #22 removed the brief from the resident. The brief had a large amount of strong smelling urine and a small bowel movement in it. The skin to the coccyx area was observed and there were no open areas was observed. At 10:00 A.M., the resident was transferred from her bed into her wheelchair. At 10:50</p>			

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	<p>A.M., the resident continued to be seated in her wheelchair in her room in front of the television set. At 12:15 P.M., the resident was assisted in her wheelchair by her husband to the dining room for lunch. The resident was not checked or changed and was not offered to be toileted by the staff prior to going to the dining room.</p> <p>During an interview, on 6/10/16 at 9:47 A.M., CNA #22 indicated Resident #63 was incontinent and wore a brief. She indicated the resident was combative with care at times so they just did the best they could. CNA#22 indicated the resident is unable to tell the staff when she needed to go so the staff just checked her.</p> <p>During an interview, on 6/10/16 at 12:02 P.M., LPN #23 indicated when the resident was first admitted she was continent but she had a decline and is incontinent now and should be checked and changed every 2 hours by staff.</p> <p>During an interview, on 6/10/16 at 2:30 P.M., the Corporate MDS Coordinator indicated a bladder assessment should have been completed when the resident had a decline in her continence. The MDS Coordinator indicated a care plan indicating the resident was continent of urine on admission should have been</p>			

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F 0329 SS=D	<p>implemented and when the resident declined in her urinary continence.</p> <p>On 6/10/16 at 3:25 P.M., the Corporate Nurse Consultant provided a policy titled "Continence Assessment," dated 05/2013 with no revision date, and indicated the policy was the one currently used by the facility. The policy indicated "...Each resident's continence will be assessed no less often than quarterly to assure proper provision of care...1. The Bowel and Bladder monitoring record will be initiated upon admission and during the assessment reference period for all subsequently scheduled MDS assessments. 2. The Bowel and Bladder monitoring record will be completed for 72 consecutive hours. 3. The continence care plan will be based on the resident's comprehensive assessment including but not limited to the Bowel and Bladder monitoring period...5. The Care Planning/Interdisciplinary Team is responsible for maintaining care plans on a current status...."</p> <p>3.1-41(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM</p>				

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Bldg. 00	<p>UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interviews, the facility failed to ensure medical symptoms were monitored for 1 of 5 residents reviewed for unnecessary medications. (Resident #17)</p> <p>Finding includes:</p> <p>The clinical record for Resident #17 was reviewed on 06/13/2016 at 9:31 A.M. Resident #17 was admitted to the facility, on 02/03/16, with diagnoses, including but not limited to: major depressive disorder recurrent severe with psychotic symptoms, abnormal gait and mobility,</p>	F 0329	<p>In response to state findings regarding F 329:</p> <p>Element One: Resident #17's medical symptoms were clarified on the current behavior logs.</p> <p>Element Two: Behavior logs for residents receiving psychotropic medications were clarified for specific related behavioral symptoms.</p> <p>Element Three: All staff will be in-serviced regarding documentation requirements as it pertains to the behavior logs for each resident. In-servicing to be completed by July</p>	07/10/2016

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	<p>ankle contracture, generalized anxiety disorder, dementia, muscle wasting, osteoporosis, hyperlipidemia, hypokalemia, insomnia, retention of urine, restless legs syndrome, psychotic disorder with delusions and allergic rhinitis</p> <p>The current physician's orders regarding medications included the following: *Depakote (a mood stabilizer) 500 mg (milligram) one tablet every am for psychotic disorder with delusions and 500 mg two tablets at bedtime for psychotic disorder with delusions, *Melatonin (a supplement to treat insomnia) 5 mg one tablet at bedtime for insomnia, *Fluoxetine (Prozac) (an antidepressant) 10 mg one tablet every morning, *Olanzapine (Zyprexa) (an antipsychotic) 7.5 mg at bedtime to treat depression.</p> <p>The current care plan regarding the resident's mood and behaviors indicated the resident exhibited insomnia, irrational fears, delusional/paranoid ideations and statements, false reporting, verbal threats to staff, repetitive verbalizations, non-essential call light use, repetitive and excessive non-essential requests for food and incontinence supplies, self-deprecating and negative statements, tearfulness, poor coping with life</p>		<p>8, 2016.</p> <p>Element Four: SS/Designee will review the behavior logs for complete documentation 5 times per week for 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks. If audit shows 100% compliance, audit will be discontinued. Results of audit will be submitted to Quality Assurance Committee for review, any negative outcomes may result in additional action plans to achieve compliance.</p> <p>Woodland Manor maintains that complete compliance will be achieved by July 10, 2016.</p>				

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	<p>change/living arrangements wanting to move, requests for therapy but refused therapy when offered, refuses care or assist with personal hygiene. There was also a plan related to the resident's obsessive compulsive statements regarding wanting to "die in South Bend" and frequent requests to discharge to other facilities.</p> <p>During an interview, on 06/08/16 at 9:51 A.M., Resident #17 indicated she wished to be discharged to another facility.</p> <p>The behavior tracking form for Resident #17 for April, May and June 2016, indicated there were no behaviors documented. Review of the June 2016 tracking record on paper for Resident #17 indicated the resident received Melatonin for Insomnia, Paxil (sic) for Depression, and Zyprexa for dementia with delusions. There were no specific behaviors and no specific interventions denoted on the behavior tracking form.</p> <p>The progress notes, related to behaviors indicated on 05/20/16, 05/23/16 and 06/08/16. Resident #17's desired to be discharged to another facility. The 05/20/16 note also indicated the resident was asking for various food items and was upset when staff were unable to go to the kitchen to get her the food.</p>			

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	<p>There were no other notes regarding the resident's continuous behaviors documented.</p> <p>During an interview, on 06/13/16 at 10:07 A.M., LPN (Licensed Practical Nurse) #27 indicated staff were supposed to document behaviors on the behavior log forms, but she knew some of the staff were making behavior progress notes in the nursing note section.</p> <p>During an interview on 06/13/2016 at 10:14 A.M., LPN #27 indicated Resident #17 exhibited "needy" behaviors and "attention seeking" behaviors with excessive call light use and repetitive requests. She indicated it was supposed to be "tracked" and documented but it would require an almost "continuous" charting for the resident. She indicated Resident #17 had not been delusional lately.</p> <p>On 06/13/16 at 3:35 P.M., the Administrator provided the policy titled, The Behavior Management Policy, dated 05/05/16, and indicated this was the one currently uused by the facility. The policy indicated "...3. For residents who have been identified as having on-going symptoms, a Behavior Tracking form should be utilized for all observed</p>			

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	<p>symptoms. These forms are kept on each nursing station in a behavior binder...8. In addition to the above, Behavior Intervention Monthly Flow Sheets will be used in the MAR (Medication Administration Record) each month to monitor for behaviors and moods for those resident's receiving psychotropic medications. a. Specific behaviors and/or moods will be added to flow sheets to coincide with medication prescribed. b. These forms will be supplied by the facility pharmacy. c. The resident will be continually monitored while on the medications - green form will not be discontinued until medication is discontinued."</p> <p>During an interview, on 06/13/16 at 3:45 P.M., RN #26, the Corporate Nurse Consultant, indicated there should have been a "green" form and a "Mona Lisa" form regarding behavior monitoring for Resident #17, however, she indicated she could not locate any further documentation.</p> <p>3.1-48(a)(3)</p>			

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F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure food was labeled and stored in a sanitary manner in 2 of 3 nourishment refrigerators. (100/200 hallway and 400 hallway)</p> <p>Finding includes:</p> <p>On 6/9/16 from 9:57 A.M.-10:10 A.M., an observation of the nourishment refrigerators on the nursing units was conducted with the Director of Nursing during which the following was observed:</p> <p>At 9:57 A.M., on the 100/200 unit: One plastic pitcher half full of orange juice, had no date. The interior of the refrigerator had a brown sticky substance splattered on the door and all 3 interior walls. Located at the bottom of the refrigerator was a clear plastic drawer with no lid, the drawer had a brown</p>	F 0371	<p>In response to state findings regarding F 371</p> <p>Element One: Nourishment refrigerators on unit 400 and unit 200 were cleaned and sanitized and unmarked items were removed. Maintenance replaced the refrigerator on the 200 unit.</p> <p>Element Two: All refrigerators were assessed for cleanliness and no further concerns were noted.</p> <p>Element Three: All staff will be in-serviced regarding the current policy regarding food storage and cleaning of the nourishment refrigerators by July 8, 2016.</p> <p>Element Four: DON/designee will conduct random audits of the refrigerators on all three units 5 times weekly for 4 weeks, then twice weekly for 4 weeks and then weekly for 4 weeks to ensure compliance. If audit shows 100% compliance, audit will be discontinued. Random nursing round audits will continue.</p>	07/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155086	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2016
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NAME OF PROVIDER OR SUPPLIER WOODLAND MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 343 S NAPPANEE ST ELKHART, IN 46514
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	<p>sticky substance across the bottom of it. Several bologna sandwiches in plastic bags were observed in the drawer on top of the brown sticky substance, the sandwiches had cans of soft drinks and fruit juice bottles stacked on top of them. The rubber gasket at the bottom of the refrigerator door was torn and hanging loose from the door which allowed the gasket to sweep across the dirty floor below it. The tile floor beneath the refrigerator had loose rust particles and the tile was sticky when walked across. The rubber baseboard trim around the refrigerator was not attached to the wall and was leaned against the base of the refrigerator.</p> <p>At 10:10 A.M., on the 400 unit: The plastic drawer at the bottom of the refrigerator and the interior walls of the refrigerator had a red/brown/yellow sticky substance on it. Located inside the plastic drawer on top of the discolored sticky substance were 5 peanut butter and jelly sandwiches in plastic bags.</p> <p>During an interview, on 6/9/16 at 10:14 A.M., the Director of Nursing indicated it was the responsibility of the nursing staff to clean and check the temperatures of the nourishment refrigerators and discard any expired food. She indicated her expectation would be for the nourishment</p>		<p>Results of audit will be submitted to Quality Assurance Committee for review, any negative outcomes may result in additional action plans to achieve compliance.</p> <p>Woodland Manor maintains that complete compliance will be achieved by July 10, 2016.</p>	

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F 0465 SS=D Bldg. 00	<p>refrigerators to be kept clean.</p> <p>On 6/9/16 at 12:15 P.M., the Corporate Consultant Nurse provided policy titled "Nutritional Supplements and Snacks", dated 05/2011 with no revision date, and indicated the policy was the one currently used by the facility. The policy indicated "...Nutrition Room: 7. Kitchen will supply HS snacks with date of preparation noted on snack. 8. Nursing will date personal snacks with date of delivery and intended resident's name. 9. The snacks will be kept in the nutrition room/refrigerator and are used for resident use...11. The hydration room/refrigerator will be cleaned weekly by nursing and as needed with mild soap and water...."</p> <p>3.1-21(i)(3)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure 1 of 14 room furnishing had a covebase attached to the wall. (Resident #22)</p> <p>Finding includes:</p>	F 0465	<p>In response to state finding regarding F465</p> <p>Element One: Hole in the wall of resident #22 has been repaired and cove base replaced.</p>	07/10/2016			

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	<p>On 6/7/16 at 10:47 A.M., Resident #22's covebase was observed to be pulled away from the wall next to the bathroom entrance and a large hole was observed in he wall.</p> <p>During an environmental tour, on 6/13/16 from 1:20 P.M. thru 2:05 P.M., accompanied by the Maintenance Director and the Administrator, the following was observed: Resident #22's room had a covebase near the restroom entrance. The covebase was observed to be pulled away from the wall exposing a deteriorated, crumbling wall underneath. During an interview, on 06/13/16 at 2:00 P.M., the maintenance Director and the Administrator indicated the covebase area was unacceptable. Both the Maintenance Director and the Administrator indicated the area was unacceptable.</p> <p>3.1-19(f)</p>		<p>Element Two: Acomplete room audit was completed and areas of concern were corrected bymaintenance.</p> <p>Element Three: Allstaff will be in-serviced, by July 8, 2016, regarding the prompt placement ofmaintenance concerns in the Tels program for maintenance to address. Maintenance will monitor for wall damageduring routine room checks.</p> <p>Element Four: Maintenance/designee will conduct room audits2 times per week for four weeks, if audit shows 100% compliance room auditswill be reduced to follow monthly room check schedule. Results of audit will be submitted to QualityAssurance Committee for review, any negative outcomes may result in additionalaction plans to achieve compliance.</p> <p>Woodland Manor maintains that complete compliance will beachieved by July 10, 2016.</p>	