

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155726	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/19/2013
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NAME OF PROVIDER OR SUPPLIER WOODLANDS AT RIVER TERRACE ESTATES	STREET ADDRESS, CITY, STATE, ZIP CODE 400 CAYLOR BLVD BLUFFTON, IN 46714
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 11,12,13,14,15, 18 and 19, 2013</p> <p>Facility number: 003575 Provider number: 155726 AIM number: 200395060</p> <p>Survey Team: Julie Call, RN, TC Sue Brooker, RD Angela Strass, RN (March 11,12,13,14,15 and 18, 2013) Virginia Terveer, RN</p> <p>Census bed type: SNF: 19 SNF/NF: 10 Residential: 45 Total: 74</p> <p>Census payor type: Medicare: 4 Medicaid: 8 Private: 62 Total: 74</p> <p>Residential Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410</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>IAC 16.2.</p> <p>Quality review completed on March 22, 2013 by Randy Fry RN.</p>			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review the facility failed to ensure notification of the resident's legal representative or family member for 2 of 3 residents reviewed who had</p>	F000157	Skin wounds and family notification 1. Corrective actions put in place for resident found to be affected by alleged deficient practice. 2. All residents have the potential to be affected by the	04/08/2013			

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	<p>non-pressure related skin wounds (Residents #12, #13) and 1 of 4 residents who met the criteria for falls. (Resident # 2)</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 13 was reviewed on 3/12/13 at 9:30 a.m.</p> <p>Resident #13's diagnoses included but were not limited to: end stage dementia, incontinence, arthritis, depression. Resident # 13 became a hospice patient on 03-04-13. Resident is not interviewable, BIMS (Brief Interview for Mental Status) is 3/10 which indicated severely cognitive impairment.</p> <p>During an observation of Resident #13 on 3-11-13 at 11:50 a.m., during lunch, she was observed to have 2 steri strips intact on right elbow skin tear wounds. Resident's skin tears were pink and edges well approximated, appeared to be healing.</p> <p>On 02-19-13, one of the Non-Pressure Skin Condition Record indicated Resident #13 had a skin tear on her right elbow. The skin tear measured 2 cm(centimeters, a</p>		<p>alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. DON will develop and implement a wound assessment documentation guideline by April 1, 2013. b. ADON will review the wound documentation guideline with licensed nurses by April 1, 2013. c. ADON will review Accident/Incident Investigation Report policy, including the notification of physician and family, with licensed nursing by April 1, 2013. d. ADON will review the Care Plan update/documentation guidelines with licensed nurses by April 8, 2013. 4. Monitoring to assure that alleged practice does not reoccur: a. ADON will complete chart and incident/accident report audits for documentation completeness, notification of physician and notification of family. 100% audit will be completed for a three month period beginning April 1, 2013 and ending July 1, 2013. Audit finding will be reported to the Quality Assurance Committee quarterly. Next meeting will be May 29, 2013. Any audit deficiencies will result in one-on-one counseling with the responsible licensed nurse. Following initial audit period,</p>	

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	<p>measurement) in length x (by) 1 cm in width x no depth reported, indicated partial thickness of skin without exudate(drainage). Progress notes indicated, "...Initial Evaluation. Skin tear noted when staff assisting resident into wheelchair. Wound cleaned and steri strips applied.... Date Physician Notified: 2/20/13...Date Family Notified: (was blank)...."</p> <p>On 02-19-13, another Non-Pressure Skin Condition Record indicated Resident #13 had a skin tear on her right elbow and it measured 1.5 cm x 0.5 cm, partial thickness, no exudate. Progress notes indicated, "...Skin tear noted with staff assisting resident into wheelchair. Wound cleaned and steri strip applied....Date Physician Notified: 2/20/13...Date Family Notified: (was blank)...."</p> <p>During a review of Nurses Notes looking the for cause of the skin tears, there were no entries in the nursing notes from 2-6-13 to 2-20-13. On 2-20-13, the nurses note entry stated, "Fax out to MD(Medical Doctor) R/T(related to) S/T (skin tear) R (right) elbow N/O (Nursing Order) received et noted." There were no entries that indicated Resident #13's family was</p>		<p>random audits will be conducting monthly and appropriate corrective action taken if needed. F157 Fall</p> <p>1. Corrective actions put in place for resident found to be affected by alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. ADON will review the fall policy, including notification of the family, with licensed nursing by April 1, 2013. 2. Monitoring to assure that alleged practice does not reoccur: a. ADON will complete a three month 100% chart audit for fall documentation, incident/accident report, physician notification/documentation and family notification/documentation from April 1, 2013 to July 1, 2013. Following initial audit period, random audits will be conducting monthly and appropriate corrective action taken if needed. b. Audit report will be reported to the DON monthly and the Quality Assurance Committee quarterly. Next meeting May 29, 2013. c. Any audit deficiencies will result in one-on- one counseling with the responsible licensed nurse.</p>				

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	<p>notified of Resident #13's skin tears or the physician orders for treatment.</p> <p>During an interview with LPN # 2 on 3-12-13 at 1:58 p.m., she indicated the eve or night nurse had written a physician's order to be faxed on the morning of 2-20-13 for the skin tear treatment. LPN #2 indicated that the nurse's notes should indicate what happened that caused the skin tears. When reviewing the nurses notes with LPN #2, she indicated her notation on 2-20-13 for the fax to MD, related to the skin tears to Resident #13's right elbow, LPN #2 indicated the Physician's order was received and noted. LPN #2 indicated there were no nurses notes about the skin tear or if the family was notified.</p> <p>During an interview with the ADON on 3-12-13 at 2:18 p.m., indicated all incidents involving a resident should be reported to resident's family and noted in resident's medical records.</p> <p>2. The clinical record for Resident # 12 was reviewed on 3-14-13 at 9:30 a.m.</p> <p>Resident # 12's diagnoses included but were not limited to: Alzheimer's dementia with psychosis, hypokalemia, TIA (transient ischemic</p>			

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	<p>attack,"mini-stroke"), Seasonal allergies, recurrent UTI (urinary tract infection), osteoarthritis. Resident # 12 was not interviewable, she was rarely able to express herself or understand staff.</p> <p>During an observation of Resident #12's skin on 03-12-13 at 10:09 a.m., a dark purple bruise was seen on the top of her right hand. Resident #12 had geri sleeves that covered her bilateral (both) arms and geri sleeves on her bilateral lower legs and socks on her feet.</p> <p>During review of nurses noted for Resident #12, there were no entries that indicated the physician or family had been notified of bruise on top of right hand. There was not a Non-Pressure Skin Condition Record completed for the bruise on Resident #13's hand.</p> <p>On 10-31-12, the Non-Pressure Skin Condition Record indicated Resident #12 had a skin tear on her left lower arm, measured 3 cm x 1.5 cm, partial thickness of skin. Progress notes indicated, "...Resident #12 opened old skin tear. Steri Strips applied and dry dressing placed over area. Date Physician Notified: (was blank), Date</p>			

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	<p>family Notified: (was blank).</p> <p>During review of nurses noted for Resident #12, there were no entries that indicated the physician or the family had been notified of skin tear on 10-31-12.</p> <p>On 11-20-12, the Non-Pressure Skin Condition Record, progress notes indicated, "...Resident #12's left 2nd toe was red, swollen, toenail, appear ingrown. Date Physician Notified: 11-20-12. Date Family Notified: (was blank)..." There was no documentation that indicated the family was notified of red swollen toenail.</p> <p>On 01-18-13, the Non-Pressure Skin Condition Record indicated Resident #12 had a skin tear on her right elbow, measured 1 cm x 0 cm x 0 cm, partial thickness. the progress notes indicated, "...Initial evaluation, Skin tear, steri strips applied with bandaid. Date Family Notified: (was blank)..."</p> <p>During review of nurses noted for Resident #12, there were no entries that indicated the family was notified of the skin tear on 01-18-13.</p> <p>During an interview with ADON on 3-14-13 at 11:20 a.m., she indicated</p>			

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	<p>the resident's family should be notified when a resident has a skin tear and a treatment was done. The ADON indicated the resident's family notification should have been documented on the initial wound assessment sheet or in the nurses notes.</p> <p>3. On 3/13/13 at 9:30 a.m. review of the clinical record for resident #2 indicated she was admitted to the facility on 4/11/12 with Diagnoses including but not limited to dementing illness with behavioral symptoms, anxiety and osteoporosis. Review of nursing notes dated 3/12/13 indicated "Resident fell at 4:30 p.m. getting up out of wheelchair and landed on bottom. No injuries noted at this time. BP (blood pressure)175/88 P(pulse) 86, R (respirations) 22 T (temperature) 98.0. Resident sitting on floor at end of roommates bed. Faxed MD."</p> <p>Interview with the ADON (assistant director of nursing) on 3/13/13 at 1:45 p.m. indicated the nurse had faxed</p>			

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	<p>the physician related to the residents fall but had not contacted the residents responsible party to inform them the resident had fallen.</p> <p>On 3/12/13 at 4:00 p.m., DON provided the facility's Standards and Guidelines, Policy # 12015, Resident Rights: Notification of Changes, not dated, the Policy stated, "...Licensed Nursing Home will immediately notify the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member of changes....5. Notification will occur when there is: a. An accident involving the resident which results in injury and has the potential for requiring physician intervention:...c. A need to alter treatment significantly...."</p> <p>3.1-5(a)(1)(3)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review the facility failed to initiate a care plan for urinary incontinence for 2 of 2 residents who met the criteria for urinary incontinence (Resident #2 and Resident #20).</p> <p>Findings include:</p> <p>1. On 3/13/13 at 9:30 a.m. review of the clinical record for resident #2 indicated she was admitted to the facility on 4/11/12 with Diagnoses including but not limited to dementing</p>	F000279	F279 1. Corrective actions put in place for resident found to be affected by alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. ADON will review the resident care plan policy with licensed nurses by April 8, 2013. b. Resident care plans will be kept in a binder at the nurses' desk. Nurses will update the care	04/08/2013	

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	<p>illness with behavioral symptoms, anxiety and osteoporosis.</p> <p>On 3/13/13 at 10:00 a.m. review of a significant change MDS (minimum data set) assessment dated 11/19/12 indicated resident #2 was frequently incontinent of urine and required limited assistance of 1 staff for toileting. Review of the resident's care plans did not indicate a care plan addressing the resident's incontinence.</p> <p>On 3/14/13 at 11:25 a.m. interview with the MDS Coordinator indicated the resident was incontinent of urine and there should have been a plan of care addressing the resident's incontinence of urine.</p> <p>On 3/14/13 at 2:00 p.m. interview with CNA #1 indicated the resident is incontinent of urine but sometimes is continent.</p> <p>2. Review of the clinical record for Resident #20 on 3/14/13 at 9:03 a.m., indicated the following: diagnoses included, but were not limited to, stroke, stenosis, subarachnoid</p>		<p>plans upon readmission, significant change and/or new physician orders beginning April 8, 2013. c. MDS Coordinator will initiate new care plan within seven days of completion of the Minimum Data Set. Ongoing. d. MDS Coordinator will review all care plans weekly for updates beginning April 8, 2013. e. MDS Coordinator will utilize a notification form attached to the care plan binder to assure nursing is aware of changes beginning April 8, 2013. f. MDS Coordinator will update care plan with each scheduled MDS assessment. Ongoing. 4. Monitoring to assure that alleged practice does not reoccur: a. MDS Coordinator will monitor the completion of updated care plans weekly for three months beginning April 8, 2013 and will end July 12, 2013. Following initial audit period, random audits will be conducting monthly and appropriate corrective action taken if needed. b. Care Plan audit will be submitted to DON monthly and Quality Assurance Committee quarterly. Next meeting is May 29, 2013.</p>		

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	<p>hemorrhage, atrial fibrillation, hypertension, renal failure syndrome, cerebrovascular accident, acute kidney injury, coronary artery disease, confusion, mental illness, and hyperlipidemia.</p> <p>Resident #20 was admitted to the facility on 9/25/12.</p> <p>A Minimum Data Set Assessment (MDS) for Resident #20, dated 9/28/12, indicated he was always continent of urine.</p> <p>A Bowel and Bladder Assessment for Resident #20, dated 9/27/12, indicated he was prescribed a diuretic, required assistance with ambulation, and showed a urinary pattern greater than 2 hours.</p> <p>Review of the Skilled Daily Nurses Notes for Resident #20, dated 9/25/12 through 11/21/12, indicated he was continent of urine except on 10/22/12 and on 10/25/12.</p> <p>Facility care plans for Resident #20 did not include urinary incontinence.</p> <p>Resident #20 was discharged from the facility on 11/21/12.</p> <p>Resident #20 was re-admitted to the</p>			

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	<p>facility on 11/27/12.</p> <p>A Bowel and Bladder Assessment for Resident #20, dated 11/27/12, indicated he displayed short term memory loss, was prescribed diuretics, required assistance with ambulation and wore incontinence products. The assessment also indicated he showed a less than 2 hour pattern of continence.</p> <p>An MDS assessment for Resident #20, dated 12/11/12, indicated he was frequently incontinent of urine.</p> <p>Review of the Skilled Daily Nurses Note for Resident #20, dated 11/27/12 through 12/28/12, indicated he was incontinent of urine on: 12/3/12, 12/4/12, 12/5/12, 12/6/12, 12/7/12, 12/8/12, 12/9/12, 12/10/12, 12/11/12, 12/12/12, 12/13/12, 12/14/12, 12/15/12, 12/16/12, 12/17/12, 12/18/12, 12/19/12, 12/20/12, 12/21/12, 12/22/12, 12/23/12, 12/24/12, and 12/25/12.</p> <p>The facility care plans for Resident #20, developed on 9/27/12, were re-initiated when he was re-admitted to the facility on 11/27/12. No care plan was initiated for urinary incontinence.</p>				

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	<p>The ADON was interviewed on 3/14/13 at 10:39 a.m. During the interview she indicated when Resident #20 was admitted to the facility on 9/25/12 he was continent of urine. She also indicated when he was re-admitted to the facility on 11/27/12, his care plans from his admission on 9/21/12 should have been updated to reflect his change to incontinence of urine.</p> <p>A current undated facility policy "Standards & Guidelines", left on the table in the library, indicated "...Licensed Nursing Home will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment...The care plan will be developed within 7 days of the completion of the Minimum Data Set...The care plan may be updated at any time based on changes to the plan of care...."</p> <p>3.1-35(b)(1)</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, interview and record review, the facility failed to ensure the care plan was followed for Resident #6 for use of the personal alarm for 1 of 29 residents reviewed for care plans.</p> <p>Findings include:</p> <p>During observations of Resident #6, the following was observed:</p> <p>On 3-13-2013 at 8:56 a.m., Resident #6 was in his wheelchair wheeling self down the hall to his room without the personal alarm attached to him.</p> <p>On 3-14-2013 at 11:12 a.m., Resident #6 was in the resident lounge without the personal alarm attached to him.</p> <p>An interview with LPN #2 on 3-14-2013 at 11:13 a.m., indicated Resident #6 did not have his personal alarm attached to him.</p> <p>An interview with CNA #3 on 3-14-2013 at 1:54 p.m., indicated Resident #6 did not have the personal</p>	F000282	<p>F282 1. Corrective actions put in place for resident found to be affected by alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. ADON will review CNA assignment sheets with CNAs by April 8, 2013. b. ADON will review documentation of personal alarms with licensed nursing by April 8, 2013. c. Audit form developed and implemented on April 8, 2013. 4. Monitoring to assure that alleged practice does not reoccur: a. Charge nurse will monitor and audit person alarms daily for thirty days beginning April 8, 2013 and ending May 8, 2013. Following initial audit period, random audits will be conducting monthly and appropriate corrective action taken if needed. Audit deficiencies will be addressed one-on-one with responsible CNA. b. Audit will be reported to the DON and to Quality Assurance Committee on May 29, 2013.</p>	04/08/2013			

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	<p>alarm on all week. CNA #6 indicated she got him up this morning and her assignment list indicated he had a personal alarm. CNA #6 did not find the alarm and did not report it to the nurse. .</p> <p>An interview with the ADON on 3-14-2013 at 4:15 p.m., indicated if the staff did not find the personal alarm to place on the resident, the nurse should have been notified of the situation and another personal alarm should have been placed on the resident.</p> <p>An interview with the ADON (Assistant Director of Nursing) on 3-15-2013 at 10:11 a.m., indicated there was not documentation in Resident #6's clinical record to indicate a personal alarm was on the resident. The personal alarms are checked during the third shift to verify function. The ADON indicated the CNAs should follow their assignment sheet and place a personal alarm on the resident as indicated.</p> <p>The record review on 3-12-2013 at 2:00 p.m., indicated Resident #6 had diagnoses including but not limited to senile dementia with delusional features, diabetes, hypertension and Alzheimer's disease.</p>				

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	<p>A fall risk assessment was completed on 3-4-2013 with score of 15. A score of 10 or greater indicated a high risk for falls.</p> <p>A review of the fall risk care plan dated 2-11-2013 indicated use of the following approaches: assist with transfers and ambulation as indicated; remind resident to use walker when ambulating... and personal alarm as indicated.</p> <p>The temporary problem list dated 2-12-2013 indicated a fall on that date with the following approach "make sure personal alarm on resident at all times."</p> <p>The nurse aide assignment sheet provided by the ADON on 3-15-2015 at 8:40 a.m., indicated Resident #6 "can ambulate with assistance...personal alarm..."</p> <p>3.1-35(g)(2)</p>			
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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review, the facility failed to ensure the urinary catheter bag and drain tubing was kept off the floor for 2 of 5 residents who were reviewed for urinary catheters. (Resident #49 and #35)</p> <p>Findings include:</p> <p>1. The following observations for Resident #49 included:</p> <p>On 3-12-2013 at 12:59 p.m., 1:50 p.m. and 2:55 p.m., Resident #49 was in bed and the urinary catheter bag was on floor.</p> <p>On 3-12-2013 at 3:20 p.m., CNA (Certified Nursing Assistant) #6 entered Resident #49's room to deliver a newspaper. CNA #6 placed the newspaper on the bed above the</p>	F000315	<p>F315 1. Corrective actions put in place for resident found to be affected by alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. ADON will review catheter care policy with CNAs, Rehab and licensed nursing by April 8, 2013. b. Verbiage added to policy to include placement of bag and tubing off the floor was completed March 29, 2013. c. Audit form developed and will be implemented April 8, 2013 4. Monitoring on all three shifts (as noted on attached Catheter Tubing Audit form) to assure that alleged practice does not reoccur: a. Charge nurse will monitor and audit placement of bag and tubing daily for thirty days beginning</p>	04/08/2013			

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	<p>catheter bag which was on the floor. CNA #6 left the room and the catheter bag remained on the floor.</p> <p>On 3-12-2013 at 4:05 p.m., the CNA staff had passed water to all residents which included Resident #49. Resident #49's urinary catheter bag remained on floor.</p> <p>On 3-13-2013 at 8:57 a.m., Resident #49 was in bed and the urinary catheter bag was on the floor.</p> <p>On 3-13-2013 at 1:28 p.m., CNA staff transferred Resident #49 to her bed, lowered the bed, and the urinary drain bag was touching the floor.</p> <p>On 3-14-2013 at 8:56 a.m., Resident #49 was up in her wheelchair in her room with the urinary drain bag and drain tubing on the floor under the wheelchair.</p> <p>In an interview with CNA #3 on 3-13-2013 at 1:28 p.m., CNA #3 indicated the urinary catheter drain bag should not be on floor. CNA #3 observed the drain bag touching the floor near the drain tube and indicated she did not realize CNA #4 lowered the bed that low.</p> <p>In an interview with CNA #7 on</p>		<p>April 8, 2013 and ending May 8, 2013. Charge Nurses will continue visual monitoring on a daily basis thereafter. c. Audit deficiencies will be addressed one-on-one with responsible CNA. d. Audit findings will be reported to DON and Quality Assurance Committee meeting on May 29, 2013.</p>				

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	<p>3-13-2013 at 2:10 p.m., CNA #7 indicated he had Resident #49 on his assignment. CNA #7 indicated the protocol for the urinary catheter bag/tubing when the resident was in their room was as follows: the urinary drain bag was placed in a catheter bag cover, placed on the lower bed rail opposite the door and the drain bag and drain tubing should not touch the floor.</p> <p>In an interview/observation of Resident #49's urinary catheter bag/drain tubing on the floor with the ADON (Assistant Director of Nursing) on 3-14-2013 at 8:59 a.m., the ADON indicated the urinary catheter bag should not be on the floor.</p> <p>In an interview/observation with COTA #8 (Certified Occupational Therapist Assistant) on 3-14-2013 at 9:03 a.m., COTA #8 indicated she got Resident #49 up for breakfast and indicated the urinary drain bag/tubing should have been up off of the floor.</p> <p>The record review for Resident #49 on 3-12-2012 at 1:10 p.m., indicated the diagnoses included but were not limited to: atrial fibrillation, congestive heart failure, right ankle fracture, dementia, MRSA (Methicillin Resistant Staphylococcus aureas,</p>						

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	<p>infection resistant to certain antibiotics) in the urine, chronic kidney failure Stage IV.</p> <p>2. The following observations for Resident #35 included:</p> <p>On 3-14-2013 at 9:23 a.m., Resident #35's urinary catheter tubing was dragging on the floor while the resident was walking in hall with his walker and PTA #13 (Physical Therapy Assistant).</p> <p>On 3-14-2013 at 10:14 a.m., Resident #35 was in his wheelchair in the resident lounge with his left foot on the urinary catheter drain tubing which was on the floor.</p> <p>On 3-14-2013 at 11:05 a.m., Resident #35 was moved in his wheelchair in the resident lounge and the urinary catheter drain tubing was on the floor.</p> <p>On 3-14-2013 at 4:17 p.m., Resident #35 was sitting in his in room in his wheelchair with the urinary catheter drain tubing on the floor.</p> <p>An interview with PTA #13 on 3-14-2013 at 9:05 a.m., indicated she tried to keep the urinary catheter tubing and bag in the bag cover during walking, but sometimes the</p>						

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	<p>tubing dragged on the floor.</p> <p>An interview with CNA #1 on 3-15-2013 at 10:38 a.m., indicated the catheter bag/drain tubing must be up off of the floor, the catheter bag placed in a cover bag and the catheter bag hung on the side of the bed or under the wheelchair off of the floor.</p> <p>The record review for Resident #35 on 3-14-2013 at 3:13 p.m., indicated the diagnoses included but were not limited to: liver abscess, hypertension, congestive heart failure, urinary retention and atonic bladder.</p> <p>An undated policy titled "Catheter Care (Indwelling Catheter)" provided by the ADON (Assistant Director of Nursing) on 3-14-2013 at 11:45 a.m., indicated the purpose was to "prevent infection" and "reduce irritation". The policy addressed resident rights guidelines, guidelines for assessment, infection control and equipment, the procedure, possible related minimum data set triggers, general documentation guidelines and resident care plan documentation guidelines. The placement of the urinary catheter bag and tubing off</p>				

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	the floor was not addressed in the policy. 3.1-41(a)(2)			

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the environment was free from accident hazards by leaving a medication cart unattended in the hallway with medications out on top of the cart which had the potential to affect 14 independent, mobile residents of 29 who resided in the facility.</p> <p>Findings include:</p> <p>An observation during the medication pass on 3-13-2013 at 3:13 p.m., indicated QMA #10 (Qualified Medication Assistant) walked away from medication cart which was in the hallway. There were pills left out on top of the medication cart for Resident #34 which included vicodin 7.5/500 mg (milligrams) (a controlled substance for pain), aspirin 81 mg (heart attack prevention), clopidogrel bisulfate 75 mg (for seizure prevention) and gabapentin 300 mg (for tremors). QMA #10 returned to the medication cart at 3:18 p.m.</p>	F000323	F323 1. Corrective actions put in place for resident found to be affected by alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. ADON will review the Guidelines for Medication Administration policy with QMAs and licensed nurses on April 8, 2013. 4. Monitoring to assure that alleged practice does not reoccur: a. ADON will monitor med passes on three separate occasions on all three shifts during a one month period beginning April 8, 2013 and ending May 8, 2013. This time will also be used for coaching and reinforcement. Following initial audit period, random audits will be conducting monthly and appropriate corrective action taken if needed. b. Monitoring deficiencies will be addressed one-on-one with responsible person. c. Auditing and monitoring results will be reported to the DON and the	04/08/2013			

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	<p>An interview with the ADON (Assistant Director of Nursing) on 3-14-2013 at 4:17 p.m., indicated the nurse/QMA should not leave the medication cart in the hall unattended with medications left out on top of the cart.</p> <p>On 3-15-2013 at 8:40 a.m., the ADON provided a list of 14 residents who were independently mobile by self or wheelchair.</p> <p>A policy titled "General Guidelines for Administering Medication" dated 7-26-2006 was obtained from the ADON on 3-15-2013 at 8:40 a.m. The policy indicated "...No medication is kept on top of the cart or accessible to other residents when the cart is unattended..."</p> <p>3.1-45(a)(1)</p>		Quality Assurance Committee on May 29, 2013.				

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F000332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure it was free from a medication error rate greater than 5%, with the facility having 4 medication errors out of 51 opportunities for error, resulting in a 7.84% error rate.</p> <p>This affected 4 of 12 residents observed for medication pass (Residents #17, #1, #16 and #49) and 2 nurses and 1 QMA (Qualified Medication Aide) observed to pass medications. RN #9 (Registered Nurse), LPN #2 (Licensed Practical Nurse), and QMA #14)</p> <p>Findings include:</p> <p>1. During an observation of the medication pass on 3-13-2013 at 10:00 a.m., RN #9 gave Resident #17 an aspirin 81 mg (milligrams) with an expiration date on the bottle of 2-13. The bottle of aspirin was in the original container and labeled with the resident's name, physician and dose.</p> <p>An interview with RN #9 on 3-13-2013 at 10:00 a.m., indicated she would contact the family to get a new bottle</p>	F000332	<p>F332 1. Corrective actions put in place for resident found to be affected by alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. ADON will assign one nurse to complete a weekly audit for expiration dates for all medications beginning April 1, 2013. 2013 b. ADON will review the five medication rights with QMAs and licensed nurses by April 1, 2013. (medication, date, dose, time and route). c. Audit tool for documentation of expiration dates will be developed and implemented by April 1, 2013. d. Physician notified that Resident # 16 was unable to swallow extended-release capsule. The medication was changed on 03/21/13 to similar medication that is allowed to be crushed. Nurse will review the 'Do Not Crush' list for any extended release capsule or prior to crushing any unfamiliar medications so that other residents do not receive a</p>	04/08/2013	

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	<p>of aspirin.</p> <p>An observation/interview with the ADON on 3-15-2013 at 9:48 a.m. in the Medication Storage room, indicated the expired aspirin bottle for Resident #1 was on the counter in the medication room and Resident #17 had received the expired aspirin through 3-13-2013 when it was brought to the attention of RN #9.</p> <p>A policy titled "Expiration Dates and Compromised Medication" dated 5-9-2006 was provided by the ADON on 3-15-2013 at 8:40 a.m., indicated "when dispensed in the manufacturer's original container, the expiration date is marked by the manufacturer and shall be observed."</p> <p>2. During an observation of the medication pass on 3-14-2013 at 10:38 a.m., QMA #14 gave Resident #1 a calcium 600 mg with Vitamin D 800 IU (international units) tablet. During the medication reconciliation, Resident #1's recapitulation for February 2013, signed by the physician on 2-3-2013, indicated the order read "Calcium 600 mg + Vitamin D 200 tablet - give 1 tablet by mouth 2 times a day for osteoporosis."</p>		<p>medication that is crushed and should not be crushed. e. ADON will review the Nursing Drug Book recommendations for Novolog insulin administration with licensed nurses by April 1, 2013. f. Licensed nursing staff instructed to coordinate with Dining Services for Novolog Administration so that Nursing staff will not give Novolog injection until the meal is ready to be served, thus assuring no more than 5-10 minutes between injection time and the meal. This will prevent blood sugar level from dropping below normal.g. Dietary provided with a listing of insulin dependent diabetics so that servers will be aware of residents' nutritional needs on March 28, 2013, thus allowing staff to serve within appropriate time frame of 10 minutes from the Novolog Administration. 4. Monitoring to assure that alleged practice does not reoccur: a. ADON will monitor med passes on three separate occasions on all three shifts during a one month period beginning April 8, 2013 and ending May 8, 2013. This time will also be used for coaching and reinforcement. Following initial audit period, random audits will be conducting monthly and appropriate corrective action taken if needed. b. Monitoring deficiencies will be addressed one-on-one with responsible person. c. Auditing and monitoring results will be</p>				

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	<p>An observation/interview with the ADON (Assistant Director of Nursing) on 3-15-2013 at 9:48 a.m., indicated Resident #17's order for calcium 600 mg with Vitamin D 200 IU on the MAR (Medication Administration Record) and the recapitulation did not match the label on the bottle of calcium which read Calcium 600 mg with Vitamin D 800 IU.</p> <p>3. During an observation of the medication pass on 3-14-2013 at 10:18 a.m., QMA #14 gave Resident #16 metoprolol succinate ER (extended release) (a generic medication for Toprol XL) 25 mg orally daily for hypertension after crushing the medication and mixing in applesauce.</p> <p>During the medication reconciliation, Resident #16's recapitulation for March 2013 was signed by the physician on 3-13-2013 and indicated "may crush medications as needed - if medication is ok to crush."</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated metoprolol succinate ER tablets are scored and can be divided, but the tablets should be swallowed whole and not to crush or chew tablets.</p>		reported to the DON and the Quality Assurance Committee on May 29, 2013.				

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	<p>A "Medication Not To Be Crushed" list used by the facility was provided by the ADON on 3-15-2013 at 8:40 a.m. and Toprol XL was listed as not to be crushed.</p> <p>4. During an observation of the medication pass on 3-14-2013 at 11:33 a.m., Resident #49 was given an injection with the Novolog Flexpen 100 units/ml (milliliter) - 4 units sub q (subcutaneous) for coverage of a blood sugar of 290 by LPN #2. Resident #49 was not provided a snack or a meal until 12:24 p.m., 51 minutes after the insulin was injected.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated to "give Novolog by subcutaneous route only, 5 to 10 minutes before a meal."</p> <p>An interview with the ADON on 3-15-2013 at 10:10 a.m., indicated a resident given Novolog for coverage should have a meal or snack within 30 minutes of the injection.</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</p>						

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F000364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview and record review, the facility failed to ensure safe food storing temperatures for yogurt and mighty shakes that could have potentially affected 13 of 29 residents who used yogurt to take their medications and 5 of 29 residents who had mighty shakes ordered.</p> <p>Findings include:</p> <p>During an observation of the medication pass on 3-13-2013 from 3 p.m. to 3:50 p.m., 2 yogurt and 9 mighty shakes (a milk based nutritional supplement) were in a container on top of the medication cart without a method to keep them cold.</p> <p>The container with the yogurt and mighty shakes was observed in the medication room refrigerator during the Medication Storage task on 3-13-2013 at 9:35 a.m.</p> <p>On 3-13-2013 at 4:10 p.m., the</p>	F000364	F 364 1. Corrective actions put in place for maintaining temperature on March 14, 2013. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by March 14, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. On March 14, 2013 ice packs were added to the container of yogurt and Mighty Shakes so that residents receive items at proper temperature. b. Freezer containers to hold the yogurt and mighty shakes were ordered March 29, 2013. Will be implemented by April 8, 2013. c. A temperature log will be developed and implemented on April 1, 2013 for monitoring documentation. 4. Monitoring to assure that alleged practice does not reoccur: To prevent PHF/TCS (Potentially Hazardous Food/Temperature Controlled Sensitive) temperatures will be monitored and documented in the following schedule: a. April 2013: Temperatures will be monitored for one med pass on each of	04/08/2013

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	<p>Kitchen Manager obtained the temperature of the yogurt which was 42 degrees Fahrenheit and the temperature of the Mighty Shake was 50 degrees Fahrenheit.</p> <p>An interview with the Kitchen Manager on 3-13-2013 at 4:15 p.m., indicated the yogurt and the Mighty Shakes should be stored on ice when out on the medication cart and kept at a temperature of 41 degrees Fahrenheit or below.</p> <p>An interview with the ADON (Assistant Director of Nursing) on 3-13-2013 at 4:16 p.m., indicated she did not realize the tempature of the yogurt and mighty shake would rise so quickly.</p> <p>An interview with QMA #10 (Qualified Medication Aide) on 3-13-2013 at 4:20 p.m., indicated the afternoon medication pass takes her about 1 1/2 hours to complete.</p> <p>An undated and untitled policy provided by the ADON on 3-15-2013 at 10:17 a.m. indicated the following:</p> <p>"Refrigerated Storage 1. PHF/TCS (Potentially Hazardous Food/Temperature Controlled Sensitive) Foods must be maintained</p>		<p>three shifts daily. The temperature will be monitored at the beginning of the med pass, one hour into the med pass, and at the end of the med pass b. May 2013: Temperatures will be monitored for one med pass on each of three shifts daily. The temperature will be monitored at the beginning of the med pass and at the end of the med pass. c. June 2013: Temperatures will be monitored for one med pass on each of three shifts daily. The temperature will be monitored at the end of the med pass. d. Results of the temperature monitoring will be reported to the dietary manager and the DON monthly. e. The monitoring results will be reported to the quarterly Quality Assurance Committee May 29, 2013. f. Following initial audit period, random audits will be conducting monthly and appropriate corrective action taken if needed.</p>				

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	at or below 41 degrees Fahrenheit..." 3.1-21(a)(2)				

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review the facility failed to ensure the complete documentation for the assessment of bruises and skin tears for 2 of 3 residents who meet the criteria for non-pressure related skin conditions. (Residents # 12 and #13)</p> <p>Findings include:</p> <p>1. The clinical record for Resident # 12 was reviewed on 3-14-13 at 9:30 a.m.</p> <p>During a review of Resident #12's clinical records on 3-14-13 at 9:30 a.m., the Weekly Skin Integrity Reviews indicated, "...Skin Condition: Other (no further documentation on form) signed by nurse and dated on 10-10-12...Skin Condition: (no further</p>	F000514	F514 1. Corrective actions put in place for residents found to be affected by alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. DON will develop and implement a Wound/Pressure Ulcer Documentation Guideline by April 1, 2013. b. ADON will review the Wound/Pressure Ulcer Documentation Guideline with licensed nurses by April 1, 2013. 4. Monitoring to assure that alleged practice does not reoccur: a. ADON will complete chart audit for documentation completeness, notification of physician and	04/08/2013			

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	<p>documentation) signed by nurse and dated on 10-24-12...Skin Condition: redness (no further documentation) signed by nurse and dated on 11-27-12...Skin Condition: Skin Intact, Bruises with left elbow circled on picture of anatomical body (no further documentation) signed by nurse and dated on 12-12-12...Skin Condition: Skin Intact, Bruises (no further documentation) signed by nurse and dated on 1-16-13...Skin Condition: Skin Intact, Bruises (no further documentation) signed by nurse and dated on 3-13-13...."</p> <p>During an interview with ADON (Assistant Director of Nursing) on 3-14-13 at 11:20 a.m., she indicated the nurse should have documented the assessment and description of the resident's bruises or skin conditions on the Weekly Skin Integrity Review.</p> <p>2. The clinical record for Resident # 13 was reviewed on 3-12-13 at 9:30 a.m.</p> <p>On 02-19-13 One of the Non-Pressure Skin Condition Record indicated Resident #13 had a skin tear on her right elbow. The skin tear measured 2 cm (centimeters, a measurement) in length x (by) 1 cm in width x no depth reported, indicated</p>		<p>notification of family. 100% audit will be completed for a three month period beginning April 8, 2013. Following initial audit period, random audits will be conducting monthly and appropriate corrective action taken if needed.b. Audit finding will be reported to the DON monthly and the Quality Assurance Committee quarterly. Next meeting will be May 29, 2013. Any audit deficiencies will result in one-on-one counseling with the responsible licensed nurse.</p>		

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	<p>partial thickness of skin without exudate(drainage). Progress notes indicated, "...Initial Evaluation. Skin tear noted when staff assisting resident into wheelchair. Wound cleaned and steri strips applied.... Date Physician Notified: 2-20-13...Date Family Notified: (was blank)...." There was no documentation to determine the location of each skin tear on Resident #13's right elbow.</p> <p>On 02-19-13 Another Non-Pressure Skin Condition Record indicated Resident #13 had a skin tear on her right elbow and it measured 1.5 cm x 0.5 cm, partial thickness, no exudate. Progress notes indicated, "...Skin tear noted with staff assisting resident into wheelchair. Wound cleaned and steri strip applied....Date Physician Notified: 2-20-13...Date Family Notified: (was blank)...." There was no documentation to determine the location of each skin tear on Resident #13's right elbow.</p> <p>On 3-15-13 at 10:15 a.m., DON (Director of Nursing) provided the facility's Standards and Guidelines, Skin Protocol, dated 7/29/10, the Policy states, "...the nurse will complete the appropriate skin assessment....Documentation should</p>			

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	<p>include the following: Date observed...Location...Size...Exudates (drainage)...pain, if present: nature and frequency...Wound bed: color and type of tissue/character ...Description of wound edges and surrounding tissue...."</p> <p>3.1-50(a))(2)</p>			

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F000520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility failed to identify and implement a plan of action for the identified concerns of notification of the resident's responsible party or their family, the development and following of resident's care plans, medication administration, accident/hazards and prevention, proper food temperatures, infection control for catheters and documentation of nursing</p>	F000520	F520 1. Corrective actions put in place for residents found to be affected by alleged deficient practices. 2. All residents have the potential to be affected by the alleged deficient practice. Plan of correction will be in compliance by April 8, 2013. 3. Systemic changes will be implemented to minimize reoccurrence of alleged practice. Measures to assure alleged deficient practice does not recur: a. Survey findings were addressed with staff on March 20, 2013 so that residents	04/08/2013			

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	<p>assessment. This deficient practice had the potential to affect 29 of 29 residents residing in the facility's healthcare unit.</p> <p>Findings include:</p> <p>An interview with the DON (Director of Nursing) on 3-15-13 at 1:30 p.m., indicated the Quality Assessment and Assurance Committee were not aware of most of the identified concerns found during the annual recertification survey. These included:</p> <p>a. not notifying the resident's responsible party or family of an incident or change in treatment, b. lack of development and following of resident's care plans, c. accident/hazards and prevention, d. medication administration errors, e. not having the proper food temperatures for supplements and foods used during medication administration, f. infection control concerns for indwelling foley catheters, and g. adequate documentation of nursing assessment of skin conditions.</p> <p>There was no evidence the DON and the Quality Assessment and Assurance Committee had a system in place to identify problems, to implement plans of action, and to</p>		<p>would be identified appropriately and steps would be taken to address any issues that were identified by ISDH. b. Quality Assurance Committee meets quarterly. Next meeting is May 29, 2013. ISDH report will be presented and discussed. Identified concerns, action items, implementation plans and monitoring results will be presented to the committee by DON on May 29, 2013. c. Ongoing quarterly Quality Assurance meeting process includes submission and discussion of monthly pharmacy reviews, falls data, Casper Report data, pressure ulcers data, pain management, psychotropic drug usage and weight loss data. The DON presents this data to the committee quarterly. Other quality issues are shared from department directors/coordinators. Committee reviews data and listens to concerns from department directors. Recommendations are made by committee for improvements or monitoring. This practice will continue quarterly with the addition on May 29, 2013 of the ISDH survey results and monitoring data d. As problems are identified in the future an action plan will be developed and implemented by ADON and DON. ADON will monitor the corrective action for the identified problem. The monitoring results will be reported</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155726	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/19/2013
NAME OF PROVIDER OR SUPPLIER WOODLANDS AT RIVER TERRACE ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 400 CAYLOR BLVD BLUFFTON, IN 46714		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>monitor the implementation of the action plans through the Quality Assessment Assurance process.</p> <p>3.1-52(b)(2)</p>		<p>to the DON monthly and the Quality Assurance Committee quarterly. Preparation and execution of this plan of correction in no way constitutes an admission or agreement by River Terrace Estates of the truth of the alleged facts in this statement of deficiency and plan of correction. This plan of correction is submitted to comply with state and federal regulations. This plan of correction serves as an allegation of compliance. River Terrace Estates respectfully requests a desk review of the submitted plan of correction.</p>		