

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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F000000	<p>This visit was for the recertification and State Licensure Survey.</p> <p>Survey dates: January 21, 22, 23, 24, 27, 28, 29, 2014,</p> <p>Facility number: 000180 Provider number: 155282 AIM number: 100274190</p> <p>Survey Team: Dorothy Watts, RN, TC Terri Walters, RN Anna Villian, RN</p> <p>Census bed type: SNF: 0 SNF/NF: 106 Residential: 14 Total: 120</p> <p>Census payer type: Medicare: 10 Medicaid: 70 Other: 40 Total: 120</p> <p>Residential sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC16.2</p>	F000000	<p>Credible Allegation of Compliance and Correction:Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.</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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	Quality review was completed on February 5, 2014, by Jodi Meyer, RN			

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record</p>	F000225	F 0225What corrective action(s)	02/28/2014			

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	<p>review, the facility failed to ensure allegations of abuse were immediately reported to the Indiana State Department of Health in 1 of 4 allegations of abuse reviewed. (Resident #53, Resident #121)</p> <p>Findings include:</p> <p>On 1/21/14 at 2:10 P.M., interviewed Resident #53. Resident #53 indicated there was an incident between Resident #53 and Resident #121. Resident #53 stated she was visiting with Resident #121. During the visit, Resident #53 indicated staff kept answering for Resident #121. Resident #53 indicated a staff member approached Resident #121, very closely, accused Resident #53 of trying to "upset" Resident #121, and promptly removed Resident #53 from the unit. Resident #53 indicated staff was aware of the incident. Resident #53 indicated the resident felt as if abuse had occurred.</p> <p>On 1/24/14 at 9:25 A.M., the administrator indicated the incident between Resident #53 and Resident #121 was investigated as a concern and not as an allegation of abuse.</p> <p>On 1/21/14 at 9:25 A.M., the administrator provided the</p>		<p>will be accomplished for those residents found to have been affected by the deficient practice; Allegation was reported to the state on Jan. 21, 2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; The facility will ensure all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and certification agency). Management staff educated on interpretation of the reporting policy and procedure regarding abuse and neglect. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Management staff educated on interpretation of the reporting policy and procedure regarding abuse and neglect. All allegations of abuse will be reported to the Indiana State Department of Health. All allegations of abuse will be audited to confirm they were completed in a timely manner. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur,</p>		

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	<p>"Suggestion or Concern" form. The form indicated, Resident #53 was visiting Resident #121. Resident #53 was upsetting Resident #121. Resident #53 was asked to leave the unit and return to the resident's own unit. The form further indicated, social services discussed with Resident #53 that Resident #53 would need to be accompanied to the other unit and supervised visits with Resident #121 would be required. After Resident #53 was removed from the unit, Resident #121 was observed to have no other tearfulness and/or crying. The investigation area of the form indicated, "staff will monitor visits from Resident #53". The resolution section indicated, "visits limited".</p> <p>On 1/24/14 at 9:54 A.M., the "Abuse and Neglect" policy, provided by the Administrator at 9:15 A.M., was reviewed. The policy indicated "...residents must not be subjected to abuse by anyone including but not limited to center staff, other residents....". The policy further indicated "Alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other</p>		<p>i.e., what quality assurance program will be put into place; Administrator/DNS will report to the QA Committee monthly all allegations of abuse. Report will include audits that were completed to confirm timely reporting. Facility will continue to perform audits once monthly for the duration of the year. Q&A Committee will make recommendations if not 100% compliant.</p>		

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F000226 SS=D	<p>officials in accordance with state law, including the state survey and certification agency".</p> <p>On 1/24/14 at 11:30 A.M., the clinical record of Resident #53 was reviewed. The quarterly MDS (Minimum Data Set) Assessment dated 12/9/13 indicated, Resident #53's BIMS (Brief Interview for Mental Status) score of 15/15, Resident #53's score indicated cognitively intact.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review the facility failed to ensure written policies and procedures prohibiting the mistreatment, neglect, and abuse of residents were implemented in 1 of 4 residents reviewed for abuse. (Resident #53, Resident #121)</p> <p>Findings include:</p>	F000226	F 0226What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Allegation was reported to the state on Jan. 21, 2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; The facility will ensure all aleged violations involving mistreatment, neglect, or abuse, including	02/28/2014

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	<p>On 1/21/14 at 2:10 P.M., interviewed Resident #53. Resident #53 indicated there was an incident between Resident #53 and Resident #121. Resident #53 stated she was visiting with Resident #121. During the visit, Resident #53 indicated staff kept answering for Resident #121. Resident #53 indicated a staff member approached Resident #121, very closely, accused Resident #53 of trying to "upset" Resident #121, and promptly removed Resident #53 from the unit. Resident #53 indicated staff was aware of the incident. Resident #53 indicated the resident felt as if abuse had occurred.</p> <p>On 1/24/14 at 9:25 A.M., the administrator indicated the incident between Resident #53 and Resident #121 was investigated as a concern and not as an allegation of abuse.</p> <p>On 1/21/14 at 9:25 A.M., the Administrator provided the "Suggestion or Concern" form. The form indicated, Resident #53 was visiting Resident #121. Resident #53 was upsetting Resident #121. Resident #53 was asked to leave the unit and returned to the resident's own unit. The form further indicated, social services discussed</p>		<p>injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and certification agency). Management staff educated on interpretation of the reporting policy and procedure regarding abuse and neglect. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Management staff educated on interpretation of the reporting policy and procedure regarding abuse and neglect. All allegations of abuse will be reported to the Indiana State Department of Health. All allegations of abuse will be audited to confirm they were completed in a timely manner. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Administrator/DNS will report to the QA Committee monthly all allegations of abuse. Report will include audits that were completed to confirm timely reporting. Facility will continue to perform audits once monthly for the duration of the year. Q&A Committee will make recommendations if not 100% compliant.</p>				

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	<p>with Resident #53 the need to be accompanied to the other unit and supervised visits with Resident #121 would be required from that point on. After Resident #53 was removed from the unit, Resident #121 was observed to have no other tearfulness and/or crying. The investigation area of the form indicated "staff will monitor visits from Resident #53". The resolution section indicated "visits limited".</p> <p>On 1/24/14 at 9:54 A.M., the "Abuse and Neglect" policy, provided by the Administrator at 9:15 A.M., was reviewed. The policy indicated "...residents must not be subjected to abuse by anyone including but not limited to center staff, other residents....". The policy further indicated "Alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown origin will be reported immediately to the center administrator and to other officials in accordance with state law, including the state survey and certification agency". The policy stated, "...the center will have evidence that all alleged or suspected violations are thoroughly investigated...."</p>				

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F000246 SS=D	<p>3.1-28(a)</p> <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>A. Based on observation, interview and record review the facility failed to ensure a resident had water within reach of her only functional hand and arm and that the fluids were accessible while the resident was in bed. Resident #3</p> <p>B. Based on observation, interview, and record review, the facility failed to ensure a resident had his call light in reach for 1 of 2 residents reviewed for falls in the stage 2</p>	F000246	F0246What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Resident #96 call light was put within reach. Resident #3 water pitcher was put within reach. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected. All residents have the right to receive reasonable accommodations of needs and preferences. Staff will be	02/28/2014

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	<p>sample. Resident #96</p> <p>Findings include:</p> <p>A. During an interview and observation with Resident #3 on 1/21/14 at 2:53 P.M., Resident #3 indicated she wanted to have water or Diet Coke at her bedside so she could reach fluids whenever she wanted. Resident #3 indicated her water cup was always on the table (which was positioned near her headboard), but she couldn't reach it. Resident #3 said, "I can hold a cup with my good hand with water and drink it." At this moment, Resident #3 demonstrated the use of her functioning arm and hand by raising her left arm and hand. Resident #3 said, "I'm diabetic and I'm always thirsty." Resident #3 was lying in bed with the head of the bed slightly elevated and the water cup was on the night stand at the head of the bed and out of reach from the resident. The mobile bedside table, which was located on on the other side of the room near the foot of the bed, was covered with stacked blankets.</p> <p>Additional observations outlined as follows:</p>		<p>educated at the February meeting. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff will be educated at February meeting. Q/A Coordinator/Nurse Manager will perform random audits weekly X4, monthly X3, and Quarterly X1 year. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Q&A Coordinator/Nurse Manager will perform random audits weekly X4, monthly X3, and Quaterly X1 year. The Q&A Committee will review audit findings for 100% compliance. The committee will make recommendations for additional training and audits if not 100% compliant.</p>		

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	<p>During an observation on 1/24/14 at 2:02 P.M., and at 2:55 P.M., Resident #3 was observed lying in bed while the bedside table and the water container positioned on it remained out of Resident #3's reach.</p> <p>During an observation in the Dining Room on 1/27/13 at 11:10 A.M., Resident #3 was observed sitting in her wheelchair with an attached side table elevated. Resident #3 picked up a styrofoam cup with her left hand, drank from a straw in the cup and then placed the cup back into the cup holder attached to her wheelchair without difficulty.</p> <p>During an observation on 1/27/14 at 1:45P.M., Resident # 3 was returned to her room and transfered to the bed by CNA #10 and Restorative CNA #1. After completing Resident #3's care, the water container was left on the night stand table which was positioned outside Resident #3's reach. The mobile bedside table, which was left on the other side of the room near the foot of the bed, was covered with numerous stacked blankets and other items.</p> <p>During an interview with CNA #10 on 1/27/14 at 2:00 P.M., CNA #10</p>			

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	<p>indicated Resident #3 had water at her bedside. When CNA #10 was made aware the water was out of Resident #3's reach, CNA #10 indicated Resident #3 would call whenever she wanted a drink. CNA #10 indicated the bedside table could be positioned and used to enable Resident #3 to reach her water, but CNA #10 further indicated that the bedside table was covered with the resident's extra blankets.</p> <p>The clinical record of Resident #3 was reviewed on 1/24/14 at 11:30 A.M. The record indicated the diagnoses of Resident #3 included, but were not limited to, adhesive capsulitis of bilateral shoulders, diabetes mellitus, arthritis, cerebral vascular accident, Alzheimers disease.</p> <p>An MDS (Minimum Data Set) assessment dated 11/25/13 indicated Resident #3 had a mild cognitive impairment, needed only to have meals set up for independent eating, was impaired on one side and had no swallowing difficulties.</p> <p>The care plan for Activities of Daily Living (ADL) self care performance dated 6/7/13 listed Resident #3's goals as follows: "resident will</p>				

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	<p>maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene through next review." Interventions were as follows: "interventions eating: strength: Resident is able to feed self independently. resident is able to (Specify: hold cup, feed self, eat finger foods, etc.) independently."</p> <p>During an interview with RN #2 on 1/27/13 3:43 P.M., RN #2 indicated Resident #3 had water at her bedside and that there were no diagnoses which would prohibit her from drinking fluids while she was in bed. RN #3 was made aware the water pitcher was positioned out of Resident #3's reach at the head of the bed on the night stand and, further, that Resident #3 had expressed a desire to have water placed within reach while she was in her bed. RN #2 indicated she would replace Resident #3's water pitcher with a Kennedy cup which would be easier for the resident to handle in bed.</p> <p>The facility's policy and procedure for hydration of residents was provided by the DON and was reviewed on 1/29/14 at 12:00 Noon and it read as follows: "9. Fresh</p>				

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	<p>water will be available to the residents at bedside unless contraindicated."</p> <p>B On 1/22/14 at 11:14 A.M., Resident #96 was observed sitting in his recliner in his room. No call light was observed in reach of the resident. CNA # 2 was made aware the resident did not have his call light in reach. She reached under the bed covering of his bed and found the resident's call light. She located the call light underneath the bed linens and moved the call light to the arm of the resident's chair and pinned it in place. She indicated the Resident #96 was able to use his call light. She also indicated it would be unsafe for him to reach for the call light pinned on his bed.</p> <p>On 1/24/14 at 1:44 P.M., Resident #96's clinical record was reviewed. He had been admitted to the facility on 8/20/12. His diagnoses included but were not limited to: Dementia with lewy bodies, Parkinson's Disease, and dementia with behavioral disturbances. His current Minimum Data Set Assessment (MDS) dated 1/6/14, indicated a cognitive score of 10 (moderate</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>cognitive impairment), extensive assistance of 2 or more staff for transfers and ambulation in room and corridor. MDS dated 10/14/13 indicated a cognitive score of 13 (cognition intact), extensive assistance of 1 person for transfers and ambulation in room and corridor. MDS dated 7/23/13, indicated a cognitive score of 5 (severe cognitive impairment), extensive assistance of 1 person for transfers, and extensive assistance of 2 persons for walking in room.</p> <p>On 1/24/14 at 1:44 P.M., during clinical record review, Resident #96's nursing progress notes indicated Resident #96 had fallen on 6/28/13, 7/22/13, 10/13/13, and 1/17/14.</p> <p>On 1/28/14 at 3:43 P.M., the Director of Nursing (DON) provided a facility policy entitled, "Procedure Call Light. (revision date 2/05)." The policy included but was not limited to: "... 3. When leaving the room, place call light withih easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it..."</p> <p>3.1-3(v)(1)</p>			

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F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to ensure a resident or a resident's health care representative were notified in advance of a roommate change for 1 of 1 resident reviewed for admission, transfer and/or discharge. Resident #96</p> <p>Findings include:</p> <p>On 1/22/14 at 11:06 A.M., during interview, Resident #96 indicated he had received a new roommate and he had not be told he was getting a</p>	F000247	F0247What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;Resident #96 was notified of roommate change, however the notification was not documented in the Medical Record.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected. Residents will be notified of the room/roommate changes and notification will be documented in the Medical Record. What measures will be	02/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2014	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
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	<p>new roommate.</p> <p>On 1/27/14 at 1:50 P.M., the RN Unit Manager was made aware Resident #96 during interview, indicated he had not been notified of a new roommate moving in his room. The RN Unit Manager at that time indicated Resident #96 had a new roommate move in his room around the dates of 11/14/13 or 11/15/13. She reviewed Resident #96's nursing progress notes and indicated documentation was lacking of Resident #96 or his legal representative/ daughter of a new roommate notification.</p> <p>On 1/27/14 at 3:10 P.M., nursing progress notes of Resident #96's roommate Resident #79 were reviewed. Nursing progress note dated 11/12/13, indicated "... res (resident) and belongings transferred to room (room number/Resident 96's room) at this time. res tolerated room change well."</p> <p>On 1/28/14 at 3:20 P.M., a facility policy entitled "ROOM/ROOMMATE CHANGE(revision policy February 2002) was received and reviewed. The policy included but was not limited to: "...Prompt notification of</p>		<p>put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Social Services staff educated on policy and procedure with regard to notification of residents before room/roommate change. Audit room/roommate changes as they occur X6 months. Audit will include timely notification and documentation in the Medical Record. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Audit room/roommate changes as they occur X6 months. Audit will include timely notification and documentation in the Medical Record. Social Services will report audit findings to the Q&A committee monthly. Q&A committee will make recommendations for additional education if not 100% compliant.</p>				

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
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F000279 SS=D	<p>this move will be made to the resident, the resident's roommate and, if known, the resident's interested family member or legal representative..."</p> <p>3.1-3(v)(2)</p> <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). Based on observation, interview,</p>	F000279	F 0279What corrective action(s) will be accomplished for those	02/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2014
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	<p>and record review, the facility failed to ensure a comprehensive care plan was in place for urinary incontinence for 1 of 4 residents reviewed for urinary incontinence. (Resident # 125)</p> <p>Findings include:</p> <p>On 1/24/14 at 2:21 P.M., the clinical record of Resident #125 was reviewed.</p> <p>Resident #125 was admitted on 8/7/13 with diagnoses included but not limited to AMS (Altered Mental Status) and vascular dementia with delirium.</p> <p>The quarterly MDS (Minimum Data Set) Assessment dated 11/3/13, indicated Resident #125 BIMS (Brief Interview for Mental Status) score of 5/15, indicating severe cognitive impairment. Resident #125 required extensive assistance of one person for toileting, occasionally incontinent, and no toileting program in place.</p> <p>Care plans included but were not limited to:</p> <p>Resident has ADL (Activities of Daily Living) self care performance deficit. Interventions included but were not</p>		<p>residents found to have been affected by the deficient practice; Resident #125 was assessed and care plan was updated to reflect current status during survey process. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected. The facility will develop a comprehensive care plan for all residents that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. Care plans for current residents who are incontinent will be reviewed to ensure interventions are current. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All residents will have comprehensive care plans and assessments in place per facility policy. Facility will conduct random care plan audits to ensure timely revisions of care plan to reflect current resident medical status. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Facility will conduct random care plan audits X4</p>		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>limited to, requires assistance to use the toilet, requires direction to restroom and supervision with pericare, requires one staff participation to use toilet, prn (as needed) 2 assist.</p> <p>No toileting interval was present.</p> <p>On 1/27/13 at 9:12 A.M., interviewed RN Unit Manager. The RN Unit Manager indicated Resident #125 was toileted after rising, before and after meals, before bedtime, and as needed.</p> <p>On 1/27/13 at 9:19 A.M., observed Resident #125 assistance with toileting. Resident #125 incontinence brief was observed to be soiled.</p> <p>On 1/27/14 at 2:48 P.M., interviewed RN Unit Manager. The RN Unit Manager indicated care planning for all incontinent residents was different.</p> <p>On 1/27/14 at 2:50 P.M., interviewed MDS RN. The MDS RN indicated incontinent residents as a general facility rule are toileted upon rising, before and after meals, before activities, before bedtime, and as needed. The MDS RN further</p>		<p>weekly ,X3 Monthly, and Quarterly X1 year. Audits will be reviewed at the monthly Q&A meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547		
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	<p>indicated toileting schedules are in the care plans but it is also a general facility rule.</p> <p>On 1/28/14 at 11:31 A.M., the "Care Plan" policy provided by the DON (Director of Nursing) was reviewed. The policy indicated, " Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment". The policy further indicated, " This plan of care will be modified to reflect the care currently required/provided for the resident".</p> <p>3.1-35(a)</p>				

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547		
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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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 representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview, and record review, the facility failed to ensure the care plan was revised following 5 falls for 2 of 2 residents reviewed for falls. Resident #22, Resident #96</p> <p>Findings include:</p> <p>1. On 1/24/14 at 1:30 P.M., the clinical record of Resident #22 was reviewed.</p> <p>Resident #22 was admitted on 11/27/07, with diagnoses including but not limited to urinary frequency.</p> <p>The annual MDS (Minimum Data</p>	F000280	F 0280What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #22 and Resident #96 care plans were reviewed and updated to reflect current medical condition. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; Comprehensive care plans will 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	02/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547		
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	<p>Set) Assessment dated 12/30/13, indicated Resident #22 required one personal physical limited assistance to use the toilet. The MDS further indicated Resident #22 had no previous falls.</p> <p>The "Progress Note" dated 1/13/14 at 3:15 P.M., indicated resident was found on the floor coming out of the bathroom, slipped on wet floor and sat on the floor.</p> <p>The "Fall Risk Evaluation" dated 1/14/14 at 3:15 P.M., indicated resident normally takes self to toilet, resident instructed to ask for assistance when transferring to and from toilet.</p> <p>Care plans included but were not limited to:</p> <p>Resident is at risk for falls initiated on 4/30/13. Interventions included but were not limited to, regular bed with 2 positioning bars to aid in repositioning, initiated on 4/30/13 and revised on 10/8/13, monitor resident for significant changes in gait, mobility, positioning device, standing/sitting balance and lower extremity joint function, walks with one assist and use of rolling walker prn (as needed) initiated on 4/30/13,</p>		<p>responsibility for the resident, and other appropriate staff in disciplines as determined by the resident needs. All residents with a current safety plan on the care plan were reviewed to ensure interventions are current. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All residents will have comprehensive care plans and assessments in place per facility policy. Facility will conduct random care plan audits to ensure timely revisions of care plan to reflect current resident medical status. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The facility will conduct random care plan audits X4, monthly X3, and quarterly X 1 year. The audits will be reviewed monthly at QA meeting. The committee will make further recommendations for interventions if not 100% compliant.</p>		

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>review resident's medical record for medications or combination of medications that could predispose to falls/increase fall risk initiated on 4/30/13. No new interventions were initiated on the care plan after Resident #22's fall.</p> <p>On 1/28/13 at 10:36 A.M., interviewed Q.A. (Quality Assurance) Nurse. The Q.A. Nurse indicated after a resident experiences a fall it is determined if a new intervention is needed depending on the interventions already in place. The Q.A. Nurse further indicated prior to the fall Resident #22 took self to toilet and now required assistance of 1 staff member.</p> <p>On 1/28/14 at 11:31 A.M., the "Care Plan" policy provided by the DON (Director of Nursing) was reviewed. The policy indicated, "Care plans will also be reviewed, evaluated, and updated when there is a significant change in the resident's condition and/or in accordance with state guidelines. The plan of care will be modified to reflect the care currently required/provided for the resident".</p> <p>On 1/28/14 at 11:31 A.M., the "Prevention and Management of</p>			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>Falls Practice Guidelines" policy provided by the DoN (Director of Nursing) was reviewed. The policy indicated, "The Interdisciplinary Team should perform analysis of the precipitating events for individual resident falls and evaluate potential interventions aimed at prevention of future falls. In addition, this team should perform ongoing systemic evaluation to determine the effectiveness of the Falls Prevention Program".</p> <p>2. On 1/24/14 at 1:44 P.M., Resident #96's clinical record was reviewed. He was admitted to the facility on 8/20/12. His diagnoses included but were not limited to: Dementia with lewy bodies, Parkinson's Disease, and dementia with behavioral disturbances. His current Minimum Data Set Assessment (MDS) dated 1/6/14, indicated a cognitive score of 10 (moderate cognitive impairment), extensive assistance of 2 or more staff for transfers and ambulation in room and corridor. MDS dated 10/14/13 indicated a cognitive score of 13 (cognition intact), extensive assistance of 1 person for transfers and ambulation in room and corridor. MDS dated 7/23/13,</p>			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>indicated a cognitive score of 5 (severe cognitive impairment), extensive assistance of 1 person for transfers, and extensive assistance of 2 persons for walking in room.</p> <p>His current care plan addressed the problem of at risk for falls (initiation date of 4/30/13). Target date of 4/2/2014. Interventions were: "ENVIRONMENTAL: Low bed/Secure Mattress (scoop mattress) Date initiated 4/30/13. PERSONAL ALARM: Bed alarm with sensor pad. Recliner alarm with sensor pad, Meal chair alarm with sensor pad-check for function each shift. Date initiated 4/30/13)."</p> <p>On 1/28/14 at 1:25 P.M., the nursing progress notes regarding the falls of 6/28/13, 7/22/13, 10/13/13, and 1/17/14 were reviewed with the QA (Quality Assurance) nurse. She indicated after the 6/28/13 and 7/22/13 falls, interventions were for staff education. After the fall of 10/13/13, the QA nurse indicated no changes/interventions were initiated and alarms, low bed with secure mattress continued. After the 1/17/14 fall, counseling services were to be implemented as an intervention. She also indicated the fall care plan had not been changed</p>			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO				STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547			
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F000315 SS=D	<p>or revised after the 6/28/13, 7/22/13, 10/17/13, and 1/17/14 falls. She indicated the care plan had not been changed due to she felt that the environment for Resident #96 was as safe as it could be.</p> <p>3.1-35(d)(2)(B)</p> <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 observation, interview and record review the facility failed to ensure a resident was toileted per an individualized program in a timely manner to prevent leakage of urine and saturation of a resident's pants for 1 of 4 residents that were reviewed for urinary incontinence. Resident #3</p>	F000315	F 0315What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #3 care plan updated to reflect incontinence care needs. Staff educated in regard to care plan changes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/28/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2014
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547		
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	<p>Findings include:</p> <p>During an observation on 1/27/14 at 1:45 P.M., Resident #3 was returned to her room and transferred to the bed by CNA #10 and Restorative CNA #1. When CNA #10 and CNA #2 assisted in raising Resident #3 from her wheelchair, the backside of Resident #3's pants exhibited a large, urine saturated area which covered Resident#3's entire backside from the waist band to the crotch and front of the pants. Resident #3 was observed being positioned in her bed while incontinence care was provided and a new incontinence brief was applied. Resident #3's wheelchair was observed being taken to the shower room and cleaned by Restorative CNA #1.</p> <p>During an interview with Restorative CNA #1 on 1/27/13 at 2:00 P.M., Restorative CNA #1 indicated that she cleaned Resident #3's wheelchair because Resident #3 had saturated her incontinence brief, leaving urine on the seat of the wheelchair. Restorative CNA #1 then stated, "She is one of our biggest wetter ' s back here. She drinks a lot of fluids."</p>		<p>actions(s) will be taken; All incontinent residents have the potential to be affected. Staff educated to follow care plan interventions related to incontinence care. All residents who are incontinent were assessed for the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;Staff educated to follow care plan interventions related to incontinence care.QA Nurse/ADNS will conduct random audits on incontinent residents related to timely toileting and incontinence care needs. Audits will be conducted 4X weekly, 3X monthly, Quaterly 1X year.How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Audits will be conducted 4X weekly, 3X monthly, Quaterly 1X year. Findings will be reported to the QA committee, if not 100% compliant QA committee will make further recommendations for interventions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2014
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>During an observation and interview with CNA #13 on 1/28/14 at 1:50 P.M., Resident #3 was observed sitting on the commode in the bathroom located next to the dining room on the 400 hall. Lying on the floor a few feet away from the commode was a pair of red pants which were wet. CNA #13 indicated the red pants lying on the floor belonged to Resident #3. CNA #13 further indicated that Resident #3 had soiled the red pants on the floor with urine and that Resident #3's briefs and pants needed to be changed.</p> <p>During an interview with CNA #12 on 1/27/13 at 2:00 P.M., CNA #12 indicated that Resident #3 frequently saturated her incontinence briefs and pants. CNA #12 indicated she did not know what could be done about the frequent oversaturation of Resident #3's incontinence brief. CNA #12 indicated that perhaps she could communicate with the nurse manager to determine whether more absorbent briefs could be ordered.</p> <p>The clinical record of Resident #3 was reviewed on 1/24/14 at 11:30 A.M. The record indicated the diagnoses of Resident #26 included,</p>			

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	<p>but was not limited to, adhesive capsulitis of bilateral shoulders, diabetes mellitus, arthritis, cerebral vascular accident, Alzheimer ' s disease.</p> <p>An MDS (Minimum Data Set) assessment dated 11/25/13 indicated Resident #3 had a mild cognitive impairment and was frequently incontinent of urine (7 or more times a week).</p> <p>The care plan for Bladder Incontinence dated 6/7/13 "...BRIEF USE: Resident uses briefs, changed per staff when wet or soiled...TOILET USE: resident is totally dependent on staff for toilet use...every shift: toilet before and after meals, before activities, at bed time and offer bedpan during the night."</p> <p>The facility's policy and procedure for Incontinence Products was provided by the DON and was reviewed on 1/28/14 at 3:45 P.M., and it read as follows: "5.c. Reassessing of sizing or type of product should be done if resident has significant changes in continence, weight or problems with leakage...6. a. Type: if the product is not able to absorb the amount of</p>				

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F000323 SS=D	<p>urine lost or if product is changed when saturation point is reached."</p> <p>During an interview with the DON on 1/28/14 at 3:45 P.M., the DON indicated the facility's supplier for incontinent briefs had been contacted and that the supplier was checking for a more absorbent brief.</p> <p>3.1-41(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision, assistance and /or appropriate interventions had been initiated to prevent falls for 2 of 2 residents who met the criteria for falls in the stage 2 sample. Resident #96, Resident #22</p> <p>Findings include:</p>	F000323	F 0323What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #22 and Resident #96 will receive adequate supervision from staff and assistance devices to prevent accidents. Resident #96 call light was put into place. Resident #22 and Resident #96 care plan and safety plan were reviewed and updated. How other residents having the potential to be affected by the	02/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2014
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	<p>1. On 1/22/14 at 11:14 A.M., Resident #96 was observed sitting in his recliner in his room. No call light was observed in reach of the resident. CNA # 2 was made aware the resident did not have his call light in reach. She reached under the bed covering of his bed and found the resident's call light. She located the call light underneath the bed linens and moved the call light to the arm of the resident's chair and pinned it in place. She indicated the Resident #96 was able to use his call light. She also indicated it would be unsafe for him to reach for the call light pinned on his bed.</p> <p>On 1/24/14 at 1:44 P.M., Resident #96's clinical record was reviewed. He was admitted to the facility on 8/20/12. His diagnoses included but were not limited to: Dementia with lewy bodies, Parkinson's Disease, and dementia with behavioral disturbances. His current Minimum Data Set Assessment (MDS) dated 1/6/14, indicated a cognitive score of 10 (moderate cognitive impairment), extensive assistance of 2 or more staff for transfers and ambulation in room and corridor. MDS dated 10/14/13 indicated a cognitive score of 13 (cognition intact), extensive</p>		<p>same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected. Facility will 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. Care plans will reflect safety interventions in place. Care plans will be updated with any changes in interventions. All residents with a safety plan on the care plan related to falls will be reviewed/assessed to ensure interventions are current for that resident. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Facility will conduct random audits that will include review of resident care plan and safety plan. Staff education will be provided regarding review of falls assessment packet. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Audits will be conducted X4 weekly, X3 monthly, and quaterly X1 year. Audits will be reviewed QA committee. Committee will make recommendations for further intervention if not 100\$% compliant.</p>		

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	<p>assistance of 1 person for transfers and ambulation in room and corridor. MDS dated 7/23/13, indicated a cognitive score of 5 (severe cognitive impairment), extensive assistance of 1 person for transfers, and extensive assistance of 2 persons for walking in room.</p> <p>His current care plan addressed the problem of at risk for falls (initiation date of 4/30/13). Target date of 4/2/2014. Interventions were: "ENVIRONMENTAL: Low bed/Secure Mattress (scoop mattress) Date initiated 4/30/13. PERSONAL ALARM: Bed alarm with sensor pad. Recliner alarm with sensor pad, Meal chair alarm with sensor pad-check for function each shift. Date initiated 4/30/13)."</p> <p>His current care plan also addressed the problems of ADL (activity of daily living) care (initiation date of 4/30/13. Target date of 4/2/14. Interventions included but not limited to: "TOILET USE: Resident requires (2) staff participation to use toilet. Date initiated 4/30/2013 Revision on 1/20/14. Toilet schedule: Toilet before and after meals, before activities and at bedtime-offer urinal or toilet during the night. Date initiated 4/30/13. TRANSFER:</p>			

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	<p>resident requires (2 ps) (2 person) staff participation with transfers. Date initiated 4/30/13. Revision 1/20/14."</p> <p>On 1/28/14 at 1:25 P.M. the QA (Quality Assurance) nurse was interviewed regarding Resident 96's falls in regard to reviewing Resident 96's fall progress notes.</p> <p>Nursing progress note 6/28/13 at 3:58 P.M., indicated, "Kneeling on Right knee beside his bed, call light within reach. Up to standing position with 2 assists and amb (ambulated) to BR (bathroom), continent of urine. alert and talking, stated he rolled over. Noted horizontal 0.5 cm skin break on Left lateral forehead, oozing small amt (amount) of blood, cleansed with NS (normal saline) and left open to air."</p> <p>On 1/28/14 at 1:25 P.M., the QA nurse indicated Resident #96 had a bed alarm, chair alarm, dining room chair alarm, and a low bed with a secure mattress in place before the 6/28/13 fall. She indicated the resident had been found on the floor and his alarm had sounded for the 6/28/13 fall. She indicated the intervention initiated was to better position the resident in bed. She</p>			

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	<p>indicated staff education had been provided but was unable to provide what the staff education had been in regard to the better positioning.</p> <p>Nursing progress note on 7/22/13 at 9:46 P.M., indicated, "CNA assisting resident to toilet and resident stated he could not make it and eased resident to floor. Nurse came in to do assessment and resident assisted to bed with lift and 3 assist. No injuries noted..."</p> <p>On 1/28/14 at 1:25 P.M., the QA nurse indicated a CNA had answered Resident #96's call light and was assisting him to toilet. The resident stated he was weak and was lowered to the floor. The QA nurse indicated staff education had been provided after the fall but was unable to provide information regarding the education provided to staff. The QA nurse was made aware Resident #96's ADL (activities of daily living) care plan (initiated 4/30/13 and with a target date of 4/2/14) indicated, "...TOILET USE: Resident requires (2) staff participation to use toilet. (Date initiated 4/30/13 and revision 1/20/14).</p> <p>Nursing progress note on 10/13/13</p>						

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>at 11:01 A.M., indicated, "Res (resident) alarm sounded. CNA to room and noted res sitting/leaning toward R side with pants at ankles. Res states he 'had to go' and states was going to restroom. Noted rug burn type area to R (right) knee... "</p> <p>On 1/28/14 at 1:25 P.M., the QA nurse indicated Resident #96 had been in bed before the 10/13/13 fall. The alarm sounded and he was found on floor with his pants around his ankles. She indicated there was no intervention change after the 10/17/13 fall. She indicated his alarms and low secured bed had been continued. She indicated she felt the environment was as safe as it could be with the 3 alarms continued.</p> <p>Nursing progress note on 1/17/13 at 3:40 P.M., indicated, "...Res' (resident's) safety alarm sounded. CNA found Res leaning against closet door on Rt (right) side, crouched down on feet. Denies pain or discomfort. Examined for injuries; none noted."</p> <p>On 1/28/14 at 1:25 P.M., the QA nurse indicated the alarm had sounded and Resident #96 was found leaning against the closet</p>			

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	<p>door. She indicated staff had felt the resident was agitated and set up an appointment with a hospital counseling center (appointment date 10 days after the fall). She indicated the resident routinely received counseling services. She also indicated the fall care plan had not been changed or revised after the 6/28/13, 7/22/13, 10/17/13, and 1/17/14 falls. She indicated the care plan had not been changed due to she felt the environment for Resident #96 was as safe as it could be.</p> <p>On 1/28/14 at 1:55 P.M., the QA nurse was made aware of the problem of lack of supervision and/ or ineffective interventions being provided to prevent falls. No further information was provided.</p> <p>2. On 1/24/14 at 1:30 P.M., Resident #22's clinical record was reviewed.</p> <p>Resident #22 was admitted to the facility on 11/27/07.</p> <p>Resident #22's diagnoses included but were not limited to, Alzheimer's Disease.</p> <p>The annual MDS (Minimum Data Set) Assessment dated 12/30/13, indicated the resident required one</p>			

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	<p>personal physical limited assistance to use the toilet. The MDS further indicated, the resident was not steady when moving from a seated to standing position and required assistance to move on/off the toilet.</p> <p>The "Progress Note", dated 1/13/14 at 3:15 P.M., indicated Resident #22 was found on the floor. The resident was coming out of the bathroom, slipped on the wet floor, and sat on the floor. There was no apparent injury.</p> <p>The "Fall Risk Data Collection", dated 1/13/14 at 3:15 P.M., indicated resident had not had any falls since admission to the facility.</p> <p>The "Fall Risk Evaluation", dated 1/14/14 at 3:15 P.M., indicated resident normally takes self to bathroom and instructed the resident to ask for assistance when transferring to and from the toilet.</p> <p>Care plans included but were not limited to:</p> <p>Resident has ADL (Activities of Daily Living) self care performance deficit r/t (related to) impaired balance, limited mobility, musculoskeletal impairment, and obesity requires</p>				

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>assistance of staff with completion of ADL's. Interventions included but were not limited to, resident requires (1) staff participation to use toilet, initiated 12/31/13</p> <p>On 1/28/14 at 10:36 A.M., interviewed the Q.A. (Quality Assurance) Nurse. The Q.A. Nurse indicated Resident #22 took self to the toilet prior to fall.</p> <p>On 1/28/14 at 11:31 A.M., the DoN (Director of Nursing) provided the "Prevention and Management of Falls Practice Guidelines" policy. The policy indicated, "Implementation of interventions, including adequate supervision, consistent with resident needs...." The policy further indicated, "...should perform ongoing systemic evaluation to determine the effectiveness of the Falls Prevention Program."</p> <p>3.1-45(a)(2)</p>			

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that medications located in</p>	F000431	F 0431What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Expired medications	02/28/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155282		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2014	
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	<p>the medication storage refrigerators and medication carts had the opened dates documented on the vials and, further, that medications were returned to the pharmacy and/or disposed of in a timely manner for 1 of 2 medication rooms reviewed and 2 of 4 medication carts reviewed.</p> <p>Findings include:</p> <p>On 1/28/14 at 11:15 A.M., observations of the 2 medication storage rooms and 4 medication carts were completed.</p> <p>1. Three opened multi-dose vials (10 doses per vial) of Influenza Virus Vaccine (medication used to administer flu vaccinations) were located in the refrigerator. One of the Influenza vaccine vials had an opening date documented as 12/1/13. Two of the open Influenza vaccine vials had no opening dates documented.</p> <p>2. One 1000 ml bag of 5% Dextrose and 0.45% sodium Chloride IV Solution had an expiration date of 12/13. One 1000 ml bag of 5% Dextrose and 0.9% sodium Chloride IV</p>		<p>on Hall #200 Medication Cart and Hall #300 Medication Cart were identified, disposed of, and replaced according to facility procedure. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected. All Drugs and Biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Pharmacy Consultant will conduct quarterly inspections of medications at facility to ensure compliance with expiration date guidelines. Pharmacy provider completed inspection on 02/07/14 to ensure facility compliance by inspecting all med carts and med rooms. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Pharmacy provider will conduct quarterly inspections of all medications at facility to ensure compliance with regulations. Pharmacy provider completed inspection on 02/07 to ensure facility compliance. Nursing staff educated on open vials and expiration of drugs at February meeting. QA Coordinator will perform random audits of</p>				

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO			STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547		
(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>Solution had an expiration date of 12/13.</p> <p>During an interview with RN #5 in the Cross Roads medication storage room, behind the nurses ' station, on 1/28/14 at 12:10 P.M., RN #5 indicated the Influenza vaccine should have had the date the medication was opened documented on the bottle and the vial of medication should have been disposed of 30 days after the documented date of opening. RN #5 indicated the pharmacy checked for expired IV supplies.</p> <p>3. Located inside the drawers of the medication cart for the 200 hall were the following: One 5 ml bottle of Prednisone Solution 1% eye drops with the opening date documented on the container as 3/26/13. On bottle of Atropine Sulfate 1% Solution 2 mg/ml. No opening date was documented on the medication container. One 15 ml bottle of Robitussin DM cough syrup. No opening date was documented on the medication container.</p> <p>During an interview with RN #5 on 1/28/14 at 12:10 P.M., RN #5</p>		<p>medication carts and medication rooms X12 Monthly. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Facility will conduct monthly inspections of pharmaceuticals to confirm compliance. Pharmacy provider will conduct quarterly inspections to confirm compliance. Audit findings will be reported at monthly QA meetings. Committee will make recommendations for further interventions if not 100%.</p>		

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	<p>indicated prednisone eye drops are good for 90 days after opening the bottle and RN #5 indicated the Prednisone eye drops needed to be reordered. RN #5 further indicated all liquid medications needed to have the opening date documented on the container when they were opened and disposed of according to manufacturers' recommendations.</p> <p>4. Located in the medication cart for the 300 hall were the following medications whose containers lacked opening date documentation: One bottle of Debrox Solution 6.5%. One bottle of Robitussin DM Syrup. One bottle of Milk of Magnesia Suspension. One bottle of Mylanta Suspension.</p> <p>During an interview with RN #6 on 1/28/14 at 12:20 P.M., RN #6 indicated the order for Debrox Solution 6.5% and the Robitussin DM Syrup had been discontinued. RN #6 further indicated all liquid medications needed to be marked with the opening date.</p> <p>The facility's policy and procedure for Destruction of Medication was reviewed on 1/29/13 at 12:00 P.M. The policy and procedure read as follows: "5. The center will routinely</p>				

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	STREET ADDRESS, CITY, STATE, ZIP CODE 2515 NEWTON ST JASPER, IN 47547
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	<p>check for expired medications and necessary disposal will be done in accordance with state/pharmacy regulations." "</p> <p>3.1-25(o)</p>			