

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 12/05/2013
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NAME OF PROVIDER OR SUPPLIER PARK PLACE SENIOR LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 4411 PARK PLACE DR FORT WAYNE, IN 46845
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R000000	<p>This visit was for the Investigation of Complaint IN00139828.</p> <p>Complaint IN 00139828 Substantiated. State deficiencies related to the allegations are cited at R0036, R0052, R0217 and R0349.</p> <p>Survey dates: December 4, and 5, 2013</p> <p>Facility number: 012582 Provider number: 012582 AIM number: NA</p> <p>Survey team: Christine Fodrea, RN, TC</p> <p>Census bed type: Residential: 111 Total: 111</p> <p>Census payor type: Other: 111 Total: 111</p> <p>Sample: 4</p> <p>These State findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 6, 2013 by Randy Fry RN.</p>	R000000	<p>This plan of correction is neither an agreement of wrong doing by this facility or it' s staff members. Rather it is submitted for compliance purposes. This facility alleges substantial compliance with this Plan of Correction as of December 12, 2013 and requests paper compliance for this survey.</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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R000036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on record review and interview the facility failed to notify the physician of a change in behavior for 1 of three residents reviewed with behavior changes in a sample of 4. (Resident #Q)</p> <p>Findings include:</p> <p>Resident #Q's record was reviewed 12-4 2013 at 1:00 PM. Resident #Q's diagnoses included, but were not limited to, osteoporosis, depression, and high blood pressure.</p> <p>A review of Resident #Q's nurse's notes dated 7-3 through 8-09-2013 did not include any mention of behavior or agitation. The notes did not indicate the physician had been notified.</p> <p>A review of Behavior notes dated 8-7-2013 indicated Resident #Q</p>	R000036	<p>The new clinical director started on November 25, 2013. Nursing staff meeting held 12-12-13. Reviewed policy and procedure for Physician and family member/responsibility party notification (see attachment A) Nurses were educated on change of condition notification. See attachment B, change in condition report form. Q.M.A's/C.N.A's educated on reporting to nurse any resident behavior, see form C. Nurse is responsible to complete change in condition form and notify their physician and family member or responsible party. The behavior tracking form will then be turned into the clinical director. If behaviors are not being resolved the C.N.A. will report those concerns to the clinical director and/or general manager. Clinical director will randomly check with 5 C.N.A's weekly to make sure their concerns have been addressed (see attachment D) and resolution is being seen.</p>	12/12/2013			

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	<p>became very angry with staff when they attempted to change her wet bed. The note further indicated Resident #Q kicked at staff during this time. The notes did not indicate the physician had been notified.</p> <p>Further review of behavior notes dated 8-10-2013 indicated Resident #Q became combative and attempted to bite a staff member.</p> <p>There were no other notes indicating behaviors for review.</p> <p>In an interview on 12-4-2013 at 3:24 PM, LPN #2 indicated she was unaware of the Resident #Q's behavior on 8-7-2013. LPN #2 further indicated although Resident #Q had refusals of care from time to time, the aggressive behavior was new, and should have been brought to the attention of the physician right away to attempt to prevent further behaviors. LPN #2 indicated when Resident #Q had aggressive behavior on her shift on 8-10, the physician was notified.</p> <p>In an interview on 12-4-2013 at 3:36 PM, CNA #1 indicated although Resident #Q had refusals of care from time to time, she had not been agitated or aggressive until 8-7-2013</p>		<p>Clinical director or her designee will monitor the 24 hour sheet and check to ensure any change of condition has been properly addressed. Charge nurses on days will meet weekly with the clinical director or her designee to review all residents to help ensure continuity of care.</p> <p style="text-align: right;">12-12-1</p> <p>3/ongoing x 6 months</p>				

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	<p>when she began kicking at staff. CNA #1 indicated she notified the nurse on duty, then the Director of Nursing, but no one did anything to prevent further behavior.</p> <p>A current undated policy titled Family/ Responsible Party/ Physician notification provided by the Administrator on 12-5-2013 at 10:15 AM indicated "1. After the attending staff member has assessed resident and determined there is a change in condition, they will notify the primary care physician and the family/ responsible party."</p> <p>This State tag relates to Complaint IN00139828.</p>				

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R000052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on interview and record review the facility failed to ensure residents were free of abuse for 1 of 3 residents reviewed for abuse in a sample of 4. (Resident #Q)</p> <p>Findings include:</p> <p>Resident #Q's record was reviewed 12-4-2013 at 1:00 PM. Resident #Q's diagnoses included, but were not limited to, osteoporosis, depression, and high blood pressure.</p> <p>A review of Resident #Q's hospital Emergency Room (ER) record dated 8-11-2013 indicated Resident #Q had bruising to both wrists.</p> <p>A review of Resident #Q's nurse's notes dated 8-10-2013 indicated Resident #Q had become aggressive with staff. There was no indication staff had physical contact to avoid aggression.</p> <p>A review of behavior sheets dated 8-7</p>	R000052	<p>All staff meeting 12-12-13. Residents rights reviewed (copies on Residents Rights provided,) allowed time for questions and answers. Abuse policy (attachment E) reviewed allowing time for questions and answers. Clinical director will randomly check with 5 different nursing employees and 5 employees that are non-nursing weekly to ensure the abuse policy and residents rights are being followed and that concerns are being addressed (see attachment D). 12-12-13/ongoing x 6months. Resident interviews will be done one time weekly with one resident on each shift to ensure there are no staff concerns . See attachment G. Clinical Director and/or General Manager to review weekly. 12/23/13/ongoing x 6 months</p>	12/12/2013			

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	<p>and 8-10-2013 indicated Resident #Q was agitated and physically aggressive with biting, and kicking. There was no mention of hitting on either of the forms.</p> <p>A review of Resident #Q's nurse's notes dated 8-11-2013 indicated Resident #Q was agitated, but did not indicate a skin assessment had been done prior to being sent to ER.</p> <p>In an interview on 12-4-2013 at 3:36 PM, CNA #1 indicated Resident #Q had new behaviors on 8-7-2013. CNA #3 had been caring for Resident #Q and normally did not care for her. Additionally, the CNA #3 had been seen grabbing residents by the wrist. CNA #1 indicated the Director of Nursing (DON) in August had been notified of CNA #3's rough handling of residents, but nothing had been done until the CNA was terminated in September. CNA #1 further indicated the DON was no longer employed by the facility.</p> <p>A current undated policy titled Resident Neglect, Abuse, and Misappropriation of Property provided by the Administrator on 12-4-2013 at 10:24 AM indicated "Residents will be free from misappropriation of resident property, and verbal, sexual, physical,</p>			

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	and mental abuse, corporal punishment, and involuntary seclusion." This State tag relates to Complaint IN00139828.						

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review the facility failed to ensure accurate evaluation of behavioral needs of 1 of 3 residents reviewed for evaluation accuracy in a sample of 4.</p> <p>Findings include:</p>	R000217	Service plans are developed directly from the nursing assessment (see attachment F.) The service plans are kept in a separate binder for all nursing staff to review. Service plans will be held with the Resident/POA/responsible party at a minimum of every 6 months. They will also be redone with any	12/12/2013

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	<p>Resident #Q's record was reviewed 12-4-2013 at 1:00 PM. Resident #Q's diagnoses included, but were not limited to, osteoporosis, depression, and high blood pressure.</p> <p>Resident #Q's Service evaluation and Health Assessment dated 6-17-2013 indicated under Behavior Needs Points : The area No assistance needed-0 points was errored through without a date and initialed by LPN #4. The area interventions required daily to manage episodic behavior- 9 points had been circled. Additionally, under total service points the number zero had been errored through without initials or date and the number 9 written in.</p> <p>A review of Resident #Q's nurse's notes for the time period of 4-1-2013 to 6-17-2013 did not indicate Resident #Q had any behaviors.</p> <p>There were no behavior sheets for Resident #Q between 4-1-2013 and 6-17-2013.</p> <p>In an interview on 12-5-2013 at 9:21 AM, LPN #4 indicated the initials on the Service plan were not hers, it was not her handwriting, and Resident #Q was not having behaviors at that time. LPN #4 further indicated the Service</p>		<p>significant change in their condition requiring interventions that are not an acute process that will be resolved within 10-14 days. Day Charge nurses/Clinical director to monitor 12-12-13/ongoing x 6 months</p>				

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	<p>plans were supposed to be an accurate picture of the resident needs.</p> <p>This State tag relates to Complaint IN00139828.</p>			

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R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review the facility failed to ensure accurate evaluation of behavioral needs of 1 of 3 residents reviewed for evaluation accuracy in a sample of 4.</p> <p>Findings include:</p> <p>Resident #Q's record was reviewed 12-4-2013 at 1:00 PM. Resident #Q's diagnoses included, but were not limited to, osteoporosis, depression, and high blood pressure.</p> <p>Resident #Q's Service evaluation and Health Assessment dated 6-17-2013 indicated under Behavior Needs Points : The area No assistance needed-0 points was errored through without a date and initialed by LPN #4. The area interventions required daily to manage episodic behavior- 9 points had been circled. Additionally,</p>	R000349	<p>Each nurse is responsible for making sure the clinical record Complete, accurately documented, readily accessible and systematically organized. Closed records maintained by Shannon Roe LPN. Clinical Director to monitor when reviewing change in notification form. 12-12-13/ongoing x 6 months. All staff in-serviced 12/12/13 regarding behaviors and the necessity of reporting the behaviors. Staff will report any noted behavior immediately to a nurse, clinical director or the general manager. See attachment C for the form the C.N.A.'s will use and attachment B the nurses will use. Clinical Director or her designee to monitor. 12-23-13 ongoing x 6 months</p>	12/12/2013			

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	<p>under total service points the number zero had been errored through without initials or date and the number 9 written in.</p> <p>A review of Resident #Q's nurse's notes for the time period of 4-1-2013 to 6-17-2013 did not indicate Resident #Q had any behaviors.</p> <p>There were no behavior sheets for Resident #Q between 4-1-2013 and 6-17-2013.</p> <p>In an interview on 12-5-2013 at 9:21 AM, LPN #4 indicated the initials on the Service plan were not hers, it was not her handwriting, and Resident #Q was not having behaviors at that time. LPN #4 further indicated the documentation in the medical record was to be accurate.</p> <p>This State tag relates to Complaint IN00139828.</p>				