

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155481	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/24/2014
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NAME OF PROVIDER OR SUPPLIER  ARBOR TRACE HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3701 HODGIN RD RICHMOND, IN 47374
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: April 15, 16, 17, 21, 22, 23 &amp; 24, 2014</p> <p>Facility number: 000455 Provider number: 155481 AIM number: 100291010</p> <p>Survey team: Leslie Parrett RN, TC (April 15, 16, 17, 21, 23 &amp; 24, 2014) Angel Tomlinson RN Barbara Gray RN</p> <p>Census bed type: SNF: 32 NF: 65 Residential: 36 Total: 133</p> <p>Census payor type: Medicare: 37 Medicaid: 43 Other: 53 Total: 133</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 30, 2014 by Cheryl Fielden, RN.</p>	F000000		
F000311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment</p>			

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>and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview and record review the facility failed to implement a ambulation restorative program for a resident with difficulty walking resulting in the resident declining in ambulation and not being able to leave the facility with a family member due to the decline in function for 1 of 1 residents reviewed for ambulation for 1 resident who met the criteria for activities of daily living (Resident #157).</p> <p>Findings include:</p> <p>Review of the record of Resident #157 on 4/21/14 at 9:15 a.m., indicated the resident's diagnoses included, but were not limited to, weakness, difficulty walking, anxiety, dementia, Alzheimer's disease, pain and diabetes mellitus.</p> <p>The Admission Minimum Data Set (MDS) assessment for Resident #157 dated, 12/26/13 indicated the following: It was very important to the resident to do his favorite activities and very important to go outside and get fresh air when the weather was good.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #157 dated, 1/30/14 indicated the following: transfer-extensive assistance of one person, walk in room- extensive assistance of one person, eating- supervision of one person, dressing-extensive assistance of one person and toilet use- extensive assistance of one person.</p>	F000311	<p>Arbor Trace requests paper compliance <b>F 311 483.25(a)TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</b></p> <p><b>I. Resident 157 is currently on Physical Therapy caseload. II. All Physical Therapy Discharges of current residents within the past 60 days will be reviewed for Restorative needs. Any identified concern will be addressed immediately and a restorative program initiated if indicted.</b></p> <p><b>III. All nursing staff will be required to attend education on providing restorative programs as recommended by therapy. The systemic change includes the therapist will communicate to the MDS nurses, DON and Administrator when there are recommendations for restorative nursing. Nursing administration will complete a nursing rehab/restorative assessment. The MDS nurse or unit manager will document the new restorative plans on the certified nurse aide assignment sheet . Residents on new restorative plans will be reviewed weekly for one month during the facility At Risk meeting by the interdisciplinary team to determine restorative</b></p>	05/16/2014

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	<p>The therapist progress and discharge summary for Resident #157 dated, 12/20/13 to 1/16/14 indicated the start goal status on 12/20/13 was the resident ambulated 20 feet on a level surface and required moderate assistance with a front wheeled walker with verbal instructions and cues for safety. The end of goal status on 1/16/14 indicated the resident ambulated 80 feet to 100 feet (varied daily) on a level surfaces and required minimum to moderate assistance with a rolling walker for safety. The precautions were the resident was a fall risk and required frequent rests. The discharge plan and instructions were the resident would remain at the facility. The resident had exhibited optimal improvement and was discharged from therapy.</p> <p>Interview with Resident #157's family member on 4/17/14 at 9:30 a.m., indicated the resident had to change his previous life style and routine. The family member indicated when the resident was at home he walked with a walker. The family member indicated the facility no longer walked with the resident. The family member indicated the resident had lost the strength in his legs. The family member indicated the facility would not allow him to walk with the resident either. The family member indicated the resident had gotten use to sitting in a wheelchair .</p> <p>Interview with Resident #157 and the resident's family member on 4/17/14 at 12:55 p.m., indicated the resident was in therapy at one time but was discharged because it was felt the resident had met his maximum potential. The resident stated "I don't realize I can't walk". The family member indicated he use to be able to take the resident out of the facility, out to eat and home. The family</p>		<p><b>programs are provided.</b></p> <p><b>IV. The DON/Designee will audit restorative recommendations made by therapy weekly in addition to CNA restorative documentation to determine that restorative plans are implemented. This audit will continue five times weekly for 30 days, then weekly for 30 days then monthly for 10 months to total 12 months of monitoring. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 05/16/2014</b></p>		

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	<p>member indicated since the resident stopped walking it was too difficult to take him. Resident #157 indicated to the family member that he would like to go to the local seafood restaurant tonight and eat somewhere different than the facility.</p> <p>Interview with CNA #9 on 4/22/14 at 9:45 a.m., indicated she was the CNA caring for Resident #157. CNA #9 indicated she Resident #157 did not walk. CNA #9 indicated she had been working with the resident over a month and had never seen him walk or have a walker.</p> <p>Interview with RN #7 on 4/22/14 at 11:07 a.m., indicated Resident #157 could not walk at this time. RN #7 indicated approximately one week ago she attempted to walk with the resident and he took a couple steps. RN #7 indicated the resident was unable to move his feet when walking. When queried why Resident #157 had not been placed in an restorative walking program, RN #7 indicated she was unsure why therapy had not placed the resident on a program for ambulation.</p> <p>Interview with the Director of Nursing (DON) on 4/22/14 at 1:13 p.m., indicated it was therapies responsibility to initiate a restorative walking program for residents. The DON indicated if therapy does not initiate a walking program than the resident does not have one.</p> <p>Interview with CNA #8 on 4/22/14 at 1:20 p.m., indicated she use to take care of Resident #157, but had not taken care of the resident recently. CNA #8 indicated she use to walk with Resident #157 and he did very well. CNA #8 indicated the gait belt had to be on the resident and used a rolling walker.</p>			

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	<p>CNA #8 indicated Resident #157's family member had asked her to walk with the resident because it made it easier for the family member to take the resident out of the facility. CNA #8 indicated she also walked with the resident because it made it easier for her to transfer him.</p> <p>Interview with the Therapy Manager on 4/22/14 at 1:20 p.m., indicated when Resident #157 was in therapy he could ambulate approximately 80 feet with minimum to moderate assistance of one person.</p> <p>During observation on 4/22/14 at 1:55 p.m., the Therapy Manager placed a gait belt around Resident #157 waist and place a rolling walker in front of the resident. The resident was able to ambulate approximately 30 feet with moderate assistance of the Therapy Manager. The resident's knees buckled one time during this ambulation.</p> <p>Interview with the Therapy Manager on 4/22/14 at 2:07 p.m., indicated the therapist that discharged Resident #157 was not at the facility. The Therapy Manager indicated she would find out why the resident was not placed on a restorative program and she would do a new screen on the resident.</p> <p>Interview with Physical Therapy (P.T.) #13 on 4/23/14 at 11:30 a.m., indicated she had worked with the resident one time during his therapy and then did the discharge of his therapy. P.T. #13 indicated at the time of discharge she talked with the other therapist and it was felt the resident was not safe for a ambulation restorative program due to the resident would not follow directions all the time and needed a lot of encouragement.</p>			

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	<p>The resident was still doing good with transfers and mobility at the time of discharge.</p> <p>Interview with the Therapy Manager on 4/23/14 at 11:40 a.m., indicated the facility staff had not communicated to her that Resident #157 was not ambulating. The Therapy Manager indicated and LPN reported to her on 4/22/14 that he was still walking with the resident in the resident's room with a walker.</p> <p>Interview with the Therapy Manager on 4/23/14 at 1:50 p.m., indicated Resident #157 walked 150 feet with a rolling walker with minimum to moderate assistance on this day with another P.T. The Therapy Manager indicated she did not feel the resident had declined in mobility since being discharged from therapy. The Therapy Manager indicated Resident #157 was being placed back in therapy now three times a week.</p> <p>The therapy screen for Resident #157 dated, 4/22/14 at 5:00 p.m., indicated the resident was going to be re-screened per per the families request. The family reports they are no longer able to take the resident on outings due to a decline in transfers and strength.</p> <p>The "Restorative Nursing" policy provided by the MDS coordinator on 4/22/14 at 2:20 p.m., indicated the goal of the program was to promote resident wellness and when possible prevent decline and loss of independence. It is designed to promote independence by empowering and assisting residents to achieve or maintain their highest level of functioning in areas of dressing, bathing, toileting, locomotion, transfer, eating, and communication. The rehabilitation/restorative</p>			

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F000318 SS=D	<p>nursing is a process which focuses on promoting the resident's ability to achieve and maintain optimal physical, mental, and psychosocial functioning.</p> <p>3.1-38(a)(2)(B) 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview, and record review, the facility failed to provide and coordinate a Restorative Program for 1 of 3 residents reviewed for falls and 1 of 1 resident reviewed for range of motion (ROM) of 6 who met the criteria for falls and 1 who met the criteria for range of motion. (Resident #128 and #107)</p> <p>Findings include:</p> <p>1. On 4/17/14 at 1:50 P.M., Resident #128 was observed seated in her wheelchair in her bathroom adjoined to her bedroom. She indicated she was straightening items in her closet. She wheeled herself out of her bathroom into her bedroom with bilateral (both) hands and feet.</p> <p>Resident #128's record was reviewed on 4/21/14 at 10:16 A.M. Her diagnoses included but were not limited to, gait abnormality and closed intertrochanteric fracture.</p>	F000318	<p>Arbor Trace requests paper compliance <b>F 318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</b> I. Resident # 107 no longer resides in the community. Resident's #128 Certified nursing assignment sheet has been updated to reflect ambulation distance and repetitions of Active Range of Motion.</p> <p>II. All residents excluding short term rehab residents currently on therapy caseload have the potential to be affected. These residents will have a range of motion assessment completed by May 8th, 2014 to determine if there has been a decline in range of motion. Any identified concern will be addressed immediately and a restorative program initiated/modified if indicted.</p>	05/16/2014

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	<p>Resident #128's quarterly Minimum Data Set (MDS) Assessment dated 1/21/14, indicated she was understood and understood others. She scored 13 on her Brief Interview for Mental Status (BIMS), indicating she was cognitively intact for daily decision making. She required extensive assistance of 1 person for bed mobility and transfer. She required limited assistance of 1 person to walk. She required extensive assistance of 1 person for dressing, toileting, and personal hygiene. She had functional limitation impairment in her ROM of one lower extremity. She utilized a walker and wheelchair for mobility. She had received 297 minutes of occupational therapy and 292 minutes of physical therapy in the past 7 days.</p> <p>A Restorative Care Plan for Resident #128 initiated 2/27/14, indicated Resident #128 was at risk for a decline in her active range of motion (AROM) due to her weakness and decreased mobility related to a history of a hip fracture. Her goal indicated she would complete 20 repetitions of AROM to her upper and lower extremities x 2 sets through her next review. Her interventions indicated she would receive verbal cues and encouragement to complete her AROM exercises. She would be observed and her progress documented. She would be provided rest periods between repetitions. She would be referred to therapy as needed.</p> <p>A Restorative Care Plan for Resident #128 initiated 2/27/14, indicated Resident #128 was at risk for decreased walking self performance related to weakness and unsteady gait and balance. Her goal indicated she would walk to and from the</p>		<p><b>III. All nursing staff will be required to attend education on providing restorative programs per the plan of care. The systemic change will include the addition of ROM repetition and ambulation distance to the certified nurse assignment sheet by DON/Designee.</b></p> <p><b>IV. The DON/Designee will observe CNA ADL care to determine restorative plans are followed. This audit will continue five times weekly for 30 days, then weekly for 30 days then monthly for 10 months to total 12 months of monitoring. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 05/16/2014</b></p>	

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	<p>bathroom and 100 feet to each meal. She would be referred to therapy as needed.</p> <p>A Physical Therapy Evaluation for Resident #128 dated 3/19/14, indicated she would remain in the facility and continue to participate in a Restorative Nursing Program.</p> <p>On 4/21/14 at 11:56 A.M., the MDS Coordinator indicated Resident #128 was on a Restorative Program for ambulation, ROM, and Activities for Daily Living (ADL's). She indicated the CNA's provide the Restorative Programs and document the resident's participation. She indicated the CNA's document a Resident's participation in minutes in the computers Nursing Rehabilitation Time Log.</p> <p>On 4/22/14 at 11:00 A.M., CNA #3 indicated he had not walked Resident #128. He indicated he had provided her with AROM while she sat on the toilet getting dressed. He indicated she usually performed 5 repetitions with her bilateral arms and legs. He indicated any ROM he provided a resident was incorporated into their care. He indicated he was able to determine what type of Restorative Program a resident was on by utilizing his CNA Assignment Sheet or asking the Charge Nurse. He reviewed his CNA Assignment Sheet at that time and indicated Resident #128 was on a Restorative Program for ambulating to the bathroom and meals and AROM. He indicated his CNA Assignment Sheet was not specific on what all the resident needed to complete daily on the program.</p> <p>On 4/22/14 at 11:30 A.M., CNA #4 reviewed her CNA Assignment Sheet and indicated Resident #128 was on Restorative Program</p>			

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	<p>for ambulation to and from the bathroom and meals and AROM. She indicated she usually provided her ROM exercises when she first got Resident #128 up for the day. She stated "I want to say she receives AROM to her arms, shoulder, legs, finger, and wrist." She stated "I want to say it is 3 sets of 5 repetitions." She indicated her CNA Assignment Sheet was not specific on what all the resident needed to complete daily on the program.</p> <p>A copy of the CNA Assignment Sheet for Resident #128 was provided by LPN #11 on 4/22/14 at 11:21 A.M. Resident #128's Restorative documented on the CNA Assignment Sheet indicated she would ambulate to and from the bathroom and meals, and receive AROM. The CNA Assignment Sheet did not provide any specific Restorative instructions as to how far the resident would walk, how many repetitions she would perform, what extremities she would exercise, how many times a day she would perform the exercises, etc...</p> <p>2. Resident #107 was observed seated in his wheelchair on 4/17/14 at 2:18 P.M. He indicated he could lift his left leg a little. He indicated he had to use his right hand to lift his left arm and hand. He demonstrated he could extend his left leg out a very minimal amount and used his right arm to lift his left hand. His left hand and arm were limp. He indicated he was born with his left arm and hand deformity and lost the use of his left leg with a stroke. He indicated he did not perform any type of exercises.</p> <p>Resident # 107's Record was reviewed on 4/22/14 at 9:16 A.M. Diagnoses included but</p>			

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	<p>were not limited to, cerebrovascular accident (CVA), left extremity hemiplegia, leg contracture, muscle weakness, and muscle atrophy.</p> <p>Resident #107's quarterly MDS Assessment indicated he was usually understood and he understood others. He scored 15 on his BIMS, indicating he was cognitively intact for daily decision making. He required extensive assistance of 2 persons for bed mobility, transfers, and toileting. He did not walk. He required extensive assistance of 1 person for his personal hygiene and to dress. He had functional limitation in his ROM on both sides of his upper and lower extremities. He utilized a wheelchair for mobility. He received 241 minutes of physical therapy in the past 7 days. He received 6 days of ROM Restorative therapy and 7 days of Transfer Restorative therapy (for at least 15 minutes) in the past 7 days.</p> <p>A Restorative Care Plan for Resident #107 initiated 1/13/14, indicated he was at risk for decreased self performance ability with transfers related to left hemiparesis. His goal indicated he would complete 5 repetitions of sit to stand from his chair to his walker daily through his next review. His approaches indicated he would receive 2 people assistance for transfers. He would be allowed to dangle his legs over the bedside prior to assisting him to a standing position. He would be allowed to stand a few seconds to steady himself. He would be encouraged to use his arms to push up from a sitting position. His wheelchair and bed wheels would be locked prior to transfer. He would be referred to therapy as needed. He would receive verbal cues and physical assistance to complete the tasks.</p>			

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	<p>A Restorative Care Plan for Resident #107 initiated 1/13/14, indicated he was at risk for decline in AROM to his right extremities and PROM to his left extremities due to his decreased mobility, related to a CVA with left hemiplegia. His goal indicated he would complete 20 repetitions of AROM to his upper and lower extremities x 2 sets through his next review. His approaches indicated he would receive verbal cues and encouragement to complete AROM exercises. His participation and progress would be observed and documented. He would be provided rest periods between repetitions as needed. He would be referred to therapy as needed.</p> <p>A Physical Therapist Progress and Discharge Summary for Resident #107 dated 3/7/14, indicated he would participate in a Restorative Nursing Program for PROM exercises on both lower extremities.</p> <p>On 4/22/14 at 11:17 A.M., CNA #3 indicated Resident #107 had soak dentures and knee high Ted hose in the Restorative column on his CNA Assignment Sheet. He indicated Resident #107 did not walk or do any repetitive exercises.</p> <p>On 4/22/14 at 1:12 P.M., CNA #4 indicated if Resident #107 was on any type of exercise Restorative Program it would be on her CNA Assignment Sheet. She indicated Resident #107 was not on any type of exercise Restorative Program according to her CNA Assignment Sheet. She indicated Resident #107 had soak dentures and knee high Ted hose in the Restorative column on her CNA Assignment Sheet.</p>						

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	<p>On 4/22/14 at 1:32 P.M., the MDS Coordinator indicated she was responsible for writing the Resident's Restorative Programs and the CNA's were responsible to provide the residents with their Restorative Programs. She indicated the Therapy Department recommended some of the Restorative Programs after a resident was discharged from therapy. She indicated Therapy would train the CNA's on a Resident's Restorative Program if they recommended a program. She indicated a Restorative Care Plan would be initiated. She indicated the Plan of Care would be put into the Point of Care section of the Matrix (where a CNA documents). She indicated the Restorative Programs were also added to the CNA Assignment Sheet. She indicated she assured the programs were being completed by physically going out on the floor and observing. She indicated she sometimes performed the program with the residents herself to see what the resident was capable of. She indicated she also read the Restorative Nursing Program documentation in the Matrix and reviewed a resident's ADL performance documentation.</p> <p>On 4/22/14 at 1:53 P.M., CNA #5 provided an observation of Restorative documentation for Resident #107 in the Point Click Care Section of the Matrix. The programs did not provide any specific Restorative instructions. The Restorative Programs indicated the following information for staff: "Number of minutes for active range of motion (AROM)?" " Number of minutes for transferring?" The documentation provided a various number of minutes indicating Resident #107's participation in the programs on all 3 shifts daily.</p>			

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	<p>A "Restorative Nursing" policy and procedure provided by the MDS Coordinator on 4/22/14 at 2:20 P.M., indicated the following:</p> <p>"Introduction - Nursing Rehabilitation/Restorative Care emphasizes resident participation and focuses on each resident's strengths, needs, desires, as well as his or her medical problems. It asks us to look at the resident's abilities as well as their disabilities to ensure that residents retain self esteem and control throughout the care planning and delivery process. The level of intensity of services provided is determined by the resident's functional ability. The goal of the program is to promote resident wellness and when possible prevent decline and loss of independence. It is designed to promote independence by empowering and assisting residents to achieve or maintain their highest level of functioning in areas of dressing, bathing, toileting, locomotion, transfer, eating, and communication</p> <p>Definition - Rehabilitation/Restorative Nursing is a process which focuses on promoting the resident's ability to achieve and maintain optimal physical, mental, and psychosocial functioning... MDS - The MDS suggest a rehab/restorative plan (Level II) when the resident is not independent in any of the areas of ADL's listed in section G. If the resident is not independent in the areas of section G, and has no ability to make decisions (B4=3) then a maintenance plan (Level II) is suggested. Regardless of whether the resident is placed in a rehab/restorative program (Level II) or a maintenance program (Level III) they would both meet the criteria under section P3 as long as the following criteria are met:</p> <p>&gt;Measurable objective and interventions must be documented in the care plan and in the clinical record. &gt;Evidence of periodic</p>			

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	<p>evaluation by licensed nurse must be present in the clinical record. &gt;Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity. &gt;These activities are carried out or supervised by members of the nursing staff. Sometimes under licensed nurse supervision, other staff members and volunteers will be assigned to work with specific residents. &gt;This category dos not include exercise groups with more than four residents per supervising helper or caregiver. &gt;Activity occurs at least 15 minutes per day six days per week. Rehabilitation goals of several types should be considered. &gt;To restore function to maximum self-sufficiency in the area indicated. to replace hands-on assistance with a program of task segmentation and verbal cueing. &gt;To restore abilities to a level that allows the resident to function with fewer supports. &gt;To shorten the time required for providing assistance. &gt;To expand the amount of space in which self-sufficiency can be practiced. To avoid or delay additional loss of independence. &gt;To support the resident who is certain to decline in order to lessen the likelihood of complications (i.e. pressure ulcers and contractures). Resident Assessment Protocols - One of the goals of the MDS is to assist staff in identifying residents who may benefit from rehab/restorative programs. The RAPs can further assist in determining specific ADL deficits that may benefit from programming. Following completion of the MDS and RAPs the interdisciplinary team will follow the restorative algorithm charts to assist in determining appropriate restorative nursing programs... Level III Restorative Nursing Maintenance Programs - Restorative maintenance services are provided by a CNA during routine daily care. These residents</p>			

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F000323 SS=D	<p>are usually coded as no ability to make decisions (B4=3) and are not independent on section G of the MDS. These services may include: &gt;Transfer training. &gt;Brace/splint use. &gt;Dressing/grooming. &gt;Amputation/prosthetics. &gt;Communication. &gt; Range of motion (passive or active). &gt;Bed mobility/ambulation. &gt;Scheduled toileting or bladder retraining. Residents will continue at this level of service to maintain highest level of functioning."</p> <p>3.1-42(a)(2) 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 recognize the root cause analysis of a fall resulting in an implementation of an improper fall intervention and failed to implement a fall intervention for 2 of 3 residents reviewed for accidents of 6 residents who met the criteria for accidents (Resident #157 and Resident #128).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #157 on 4/21/14 at 9:15 a.m., indicated the resident's diagnoses included, but were not limited to, weakness, difficulty walking, anxiety, dementia, Alzheimer's disease, pain and diabetes mellitus.</p>	F000323	<p>Arbor Trace requests paper compliance <b>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></p> <p><b>I. Residents #157 and #128 have been reviewed and have all appropriate fall interventions in place per their plan of care.</b></p> <p><b>II. All residents with falls in the past 90 days have been reviewed to determine their fall interventions are in place per the plan of care. Any issues identified were corrected.</b></p> <p><b>III. All Licensed nursing will be required to attend education in identification of root cause for falls and placing the appropriate fall intervention.</b></p>	05/16/2014

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	<p>The Quarterly Minimum Data Set (MDS) assessment for Resident #157 dated, 1/30/14 indicated the following: transfer- extensive assistance of one person, walk in room- extensive assistance of one person, eating- supervision of one person, dressing- extensive assistance of one person and toilet use- extensive assistance of one person.</p> <p>The progress note dated, 12/27/13 at 11:05 p.m., for Resident #157 indicated the resident's chair alarm was sounding. The resident was found on the floor next to the bed. The resident was laying on his back with his legs stretched out in front of him. The resident had a walker resting upright over his head and had his hands gripping the walker as if he was trying to use the walker to pull himself up from a laying positron on the floor. The resident indicated he did not fall that he slid off the bed. The resident and staff were questioned further and then was able to piece together that the resident had been sitting in his chair and attempted to transfer himself to his bed but was unable to make it onto the bed. The resident was currently laying in bed with an alarm in place and a blue mat was placed next to the resident's bed.</p> <p>The event report dated, 12/27/13 at 11:24 p.m., for Resident #157 indicated the resident attempted to transfer from the chair to the bed and slid to the floor. The resident was in his room. The resident had been sitting in his chair near his television diagonally from the bed prior to the fall. The fall was unwitnessed. The resident's fall risk score was 13- high risk for falls. The interventions to prevent falls prior to the this fall was a low bed, chair alarm and bed alarm. The</p>		<p><b>Education will also be offered on following fall interventions according to the plan of care. The systemic change includes all fall interventions on the plan of care will be added to the Certified Nursing assignment sheets by DON/Designee.</b></p> <p><b>IV. The DON/designee will conduct walking rounds to determine fall interventions are in place per the plan of care five times a week for 4 weeks, weekly for 4 weeks then monthly thereafter for a total of 12 months. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 05/16/2014</b></p>		

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	<p>immediate intervention put in place was a mat beside the bed.</p> <p>The Interdisciplinary Team (IDT) post fall assessment dated, 12/30/13 at 10:32 a.m., for Resident #157 indicated the resident fell beside his bed. The fall was unwitnessed. The cause of the fall was lost his balance. The resident was getting up from a chair. The new immediate intervention was mat placed by the bed. The summary root cause of the fall was the resident was unsteady on his feet.</p> <p>The care plan for Resident #157 dated, 12/19/13 indicated the resident was at risk for falls related to weakness and unaware of own safety needs. The interventions to prevent falls included, but were not limited to, Mat placed next to bed (12/30/13).</p> <p>Interview with RN #7 on 4/22/14 at 11:07 a.m., indicated Resident #157 had fell on 12/27/13 and the IDT reviewed the fall on 12/30/13. When queried about a mat being placed next his bed to prevent a fall when the resident was transferring himself and wouldn't the mat cause the resident to trip and fall, RN #1 indicated the IDT did not catch that intervention of the mat as an inappropriate intervention and had been left it in place as the intervention. RN #1 indicated the mat beside his bed was not an appropriate intervention for the fall on 12/27/13.</p> <p>Interview with the MDS coordinator on 4/22/14 at 2:22 p.m., indicated the mat had been placed by Resident #157's bed on 12/27/13 because the investigation of the fall was the resident had walked from his recliner to his bed and then he slid down his bed.</p>			

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	<p>2. Resident #128's record was reviewed on 4/21/14 at 10:16 A.M. Diagnoses included but were not limited to, gait abnormality and closed intertrochanteric fracture.</p> <p>Resident #128's quarterly Minimum Data Set (MDS) Assessment dated 1/21/14, indicated she was understood and understood others. She scored 13 on her Brief Interview for Mental Status (BIMS), indicating she was cognitively intact for daily decision making. She required extensive assistance of 1 person for bed mobility and transfer. She required limited assistance of 1 person to walk. She required extensive assistance of 1 person for dressing, toileting, and personal hygiene. She had functional limitation impairment in her range of motion (ROM) of one lower extremity. She utilized a walker and wheelchair for mobility. She had received 297 minutes of occupational therapy and 292 minutes of physical therapy in the past 7 days.</p> <p>An IDT/Post Fall Assessment for Resident #128 completed 12/6/13, indicated the following: She had an unwitnessed fall on 12/6/13 at 10:49 A.M. She was found on the floor beside her bed in her room. She had stated she had tried to roll over in bed and rolled out of the bed. She had not fallen in the last 30 days. She was provided with an Emergency Room visit. The new immediate interventions initiated post fall was a bed and chair alarm.</p> <p>A Care Plan for Resident #128 initiated 12/10/13, indicated she was at risk for falls related to a history of falls and decreased</p>			

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	<p>mobility. Her goal indicated she would remain free from injury related to falls. Her interventions indicated she would be assisted with her activities of daily living (ADL's). She would have a bed alarm. Her bed would be in low position. She would be cued and reminded to use her call light to seek assistance. Her personal and frequently used items would be kept in reach.</p> <p>An IDT/Post Fall Assessment for Resident #128 completed 3/18/14, indicated the following: She had an unwitnessed fall on 3/18/14 at 10:47 A.M. She was found on the floor in her bathroom. She had slid off the toilet while transferring. She had not fallen in the last 30 days. She received basic First Aid. The new immediate intervention initiated post fall was non-skid strips on the floor in front of the toilet.</p> <p>On 3/18/14, non-skid strips on the floor in front of the toilet was added to Resident #128's Fall Care Plan.</p> <p>An IDT/Post Fall Assessment for Resident #128 completed 4/11/14, indicated the following: Resident #128 had an unwitnessed fall on 4/11/14 at 4:18 P.M. She was found on the floor beside her bed in her room. She had slid out of her wheelchair. She had been reaching down to pick her dentures up off the floor. She had 1 fall in the last 30 days. She received basic First Aid. The new immediate interventions initiated post fall was to give the resident a reacher.</p> <p>On 4/11/14, a reacher was added to Resident #128's Fall Care Plan.</p> <p>On 4/17/14 at 1:50 P.M., Resident #128 was</p>			

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	<p>observed seated in her wheelchair in her bathroom adjoined to her bedroom. She indicated she was straightening items in her closet. She wheeled herself out of her bathroom into her bedroom with her bilateral hands and feet. She indicated she had transferred herself to her wheelchair. She indicated staff did not want her getting out of bed or her wheelchair by herself. She indicated "that buzzes" and the staff know your up. She revealed a pressure pad alarm on her bed under an incontinent pad. The alarm box began alarming when she moved the pressure pad around. The MDS Coordinator entered the resident's bedroom when she heard the bed pressure pad alarm sounding. Resident #128 did not have any type of alarm on her wheelchair. The MDS Coordinator indicated she was unsure if Resident #128 was supposed to utilize a chair alarm or not.</p> <p>On 4/17/14 at 2:08 P.M., the MDS Coordinator indicated when Resident #128 had fell the initial interventions was to place an alarm on her chair. She indicated the chair alarm had been discontinued and the resident was given a reacher because she had been bending over trying to pick something up off the floor.</p> <p>On 4/17/14 at 2:10 P.M., the MDS Coordinator clipped Resident #128's call light on her bed close to her reach. Her call light had been clipped on top of her covers that was folded back against the wall out sight and out of reach.</p> <p>On 4/21/14 at 11:33 A.M., Resident #128 was observed seated in her wheelchair in her bedroom. She indicated she sometimes got up without staff's assistance. She then</p>			

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	<p>stated "I get told about it." She had a pressure pad alarm on her wheelchair seat.</p> <p>On 4/21/14 at 2:05 P.M., Resident #128 was observed lying on her back in bed. Her wheelchair was in her room with a pressure pad alarm on the seat. No alarm was visible on her bed.</p> <p>On 4/21/14 at 2:09 P.M., CNA #2 indicated she had not assisted Resident #128 in bed. She indicated the staff who assisted her had left for the day. She indicated Resident #128 did not have an alarm on her bed. She removed the pressure pad alarm from Resident #128's wheelchair and placed it on her bed. CNA #2 indicated she knew Resident #128 should have an alarm on her bed because it said so on her CNA Assignment Sheet. CNA #2 provided her CNA Assignment Sheet for review. The CNA Assignment Sheet indicated Resident #128 should have an alarm on her bed as a fall prevention device.</p> <p>On 4/21/14 at 2:20 P.M., LPN #12 indicated Resident #128's Fall Care Plan had been edited by the ADON on 4/17/14.</p> <p>On 4/21/14 at 3:31 P.M., the ADON indicated after Resident #128 rolled out of bed and went to the hospital on 12/6/13, a bed and chair alarm was added to Resident #128's Fall Care Plan. She indicated on 3/18/14, Resident #128's bed and chair alarm had been discontinued because she no longer needed them. She indicated on on 4/17/14, she added the bed alarm back on the Fall Care Plan. She indicated she added the bed alarm back on the Fall Care Plan because Resident #128 had a bed alarm sounding on her bed that day. She questioned the staff if</p>			

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F000411 SS=D	<p>Resident #128 needed the bed alarm and was informed she did. She indicated when Resident #128 fell out of her wheelchair on 4/11/14, the nurse had placed a chair alarm at that time. The Interdisciplinary Team reviewed the fall and put a reacher in place instead of a chair alarm. She indicated Resident #128 should have a bed alarm in place and not a chair alarm.</p> <p>A copy of the "Fall Management Program" provided by the MDS Coordinator on 4/22/14 at 2:20 P.M., indicated the following: "Purpose: To reduce the number of falls and minimize injuries related to falls. The goal of the interdisciplinary team is to identify residents with history of and potential for falls and develop an effective individualized fall management plan... Following each fall the plan of care must be updated with the intervention based on the root cause of the fall...."</p> <p>3.1-45(a)(2) 483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p>			

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	<p>Based on observation, interview and record review the facility failed to obtain dental services for a resident with missing lower dentures and improper fitting of upper partial dentures resulting in the resident having difficulty eating a regular diet and being downgraded to a diet with mechanical altered food and ground meat for 1 of 2 residents reviewed for dental services for 2 that met the criteria for dental status and services (Resident #157).</p> <p>Finding include:</p> <p>Review of the record of Resident #157 on 4/21/14 at 9:15 a.m., indicated the resident's diagnoses included, but were not limited to, weakness, difficulty walking, anxiety, dementia, Alzheimer's disease, pain and diabetes mellitus.</p> <p>The Admission Minimum Data Set (MDS) assessment for Resident #157 dated, 12/26/13 indicated the resident was supervision with set up only to eat.</p> <p>The record of Resident #157 indicated he was admitted to the facility on 12/19/13. The resident was admitted with a physician order for a regular diet.</p> <p>The oral cavity assessment for Resident #157 dated, 12/19/13 indicated the resident had dentures or a removable bridge.</p> <p>The speech therapy plan of care for Resident #157 dated, 1/18/14 indicated the resident was referred to therapy due to reports from nursing that the resident was having</p>	F000411	<p>Arbor Trace requests paper compliance <b>F 411 483.55(a)ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</b></p> <p><b>I. Resident #157 will have a consult with a dentist for new dentures.</b></p> <p><b>II. An audit of all residents will be completed by DON/Designee. This will include a comparison of admission dental records and/or inventory sheet. Responsible parties/family members will be contacted for residents that are unable to communicate. Any issues that are identified will be corrected.</b></p> <p><b>III. All staff will be required to attend education to report missing dentures immediately to the Administrator. The systemic change will include implementation of a grievance form for reported missing dentures. The form will be turned into social services and recommendations for dental follow up will be made at that time. Residents unable to communicate will be assessed on a quarterly basis.</b></p> <p><b>IV. The administrator or Designee will review all grievance forms for missing</b></p>	05/16/2014

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NAME OF PROVIDER OR SUPPLIER  ARBOR TRACE HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 3701 HODGIN RD RICHMOND, IN 47374		
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	<p>difficulties during meals with regular meat and poor intake. The resident had no history of dysphasia. The resident does not consistently wear his dentures causing some difficulty with meat. The underlying impairment was missing teeth. The resident may tolerate regular meats with dentures in.</p> <p>The speech therapist ordered Resident #157 to have a mechanical altered/ground meat diet on 1/24/14</p> <p>The speech therapy progress note for Resident #157 dated, 1/29/14 indicated the resident had been eating adequately for meals with a mechanical altered/ground meat trial. The resident's significant other reported this date, the resident had been asking what the food was when presented with the ground meat. The resident had upper dentures only. The resident's lower dentures were misplaced. The resident's significant other would like the resident to have regular meat, as he is afraid the resident won't eat ground meat due to the appearance.</p> <p>The physician recaptulation for Resident #157 dated, April 2014 indicated the resident was on a mechanical altered/ground meat diet.</p> <p>Interview with Resident #157's family member on 4/17/14 at 9:41 a.m., indicated the resident had difficulty chewing and eating because the resident's lower dentures were missing. The family member indicated the resident lost his dentures two weeks after he was admitted to the facility. The family member indicated he would like to get the resident new dentures as soon as the resident was available for financial assistance for them. The family member</p>		<p><b>dentures five times a week for 4 weeks, weekly for 4 weeks then monthly thereafter for a total of 12 months Any identified concerns from audits will be addressed immediately.</b></p> <p><b>The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 05/16/2014</b></p>		

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	<p>indicated the resident's upper bridge was too loose and the resident had a hard time keeping them in. The family member indicated the resident often spit out his food.</p> <p>Interview with RN #8 on 4/21/14 at 11:30 a.m., indicated Resident #157 had lost his dentures but was unsure when it happened.</p> <p>During observation on 4/21/14 at 12:03 p.m., Resident #157 was eating lasagna, broccoli and bread. The resident had his upper dentures sitting on the dining table and no lower dentures in.</p> <p>Interview with Social Services (S.S.) #10 on 4/22/14 at 8:55 a.m., indicated she was not aware that Resident #157 had lost his dentures. S.S. #10 indicated Resident #157 had not been seen by a dentist since his admission to the facility. S.S. #10 indicated the protocol when a resident's dentures were lost, the staff were to report it to Social Services and then they would set up an appointment with a dentist and have it billed to the facility.</p> <p>Interview with the Director of Nursing (DON) on 4/22/14 at 1:13 p.m., indicated the facility was working on getting Resident #157 in to see a dentist.</p> <p>Interview with CNA #8 on 4/22/14 at 1:20 p.m., indicated Resident #157's lower dentures came up missing in the first two weeks of admission. CNA #8 indicated she reported the dentures missing to a nurse and laundry. CNA #8 indicated no one ever got back with her about the missing dentures. CNA #8 indicated the lower dentures had never been found. CNA #8 indicated the resident was having a hard time eating a</p>			

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F000514 SS=D	<p>regular diet so she would cut his food up for him or give the resident chopped up meat if there was extra available.</p> <p>3.1-24(a)(3) 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 observation, interview and record review the facility failed to have an inventory list with resident's personal belongings for 1 of 2 that met the criteria for dental status and services of 14 resident record reviewed for documentation(Resident #157).</p> <p>Finding include:</p> <p>Interview with Resident #157's family member on 4/17/14 at 9:41 a.m., indicated the resident had lost his dentures two weeks after he was admitted to the facility.</p> <p>Review of the record of Resident #157 on 4/21/14 at 9:15 a.m., indicated the resident's diagnoses included, but were not limited to,</p>	F000514	<p>Arbor Trace requests paper compliance <b>F 514 483.75(l) (1)RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE I. Resident #157 had an inventory sheet completed prior to the end of the annual survey. II. The facility completed an audit of residents' medical records to determine all had inventory sheets completed. Any issues identified were corrected. III. All nursing staff will be required to attend education on completing inventory sheets on new admissions. The systemic change includes the medical record nurse will</b></p>	05/16/2014

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	<p>weakness, difficulty walking, anxiety, dementia, Alzheimer's disease, pain and diabetes mellitus.</p> <p>The record of Resident #157 did not have an inventory sheet with the resident's personal belongings listed.</p> <p>The oral cavity assessment for Resident #157 dated, 12/19/13 indicated the resident had dentures or a removable bridge.</p> <p>The Admission Minimum Data Set (MDS) assessment for Resident #157 dated, 12/26/13 indicated the resident was supervision with set up only to eat and it was very important to the resident to care of his personal belongings and things.</p> <p>Interview with RN #8 on 4/21/14 at 11:30 a.m., indicated Resident #157's family member was suppose to fill out the resident's inventory sheet. RN #8 held up a blank inventory sheet and indicated she found it in Resident #157's bedroom and it had not been filled out.</p> <p>During an observation on 4/22/14 at 9:45 a.m., Resident #157 was sitting his wheelchair. The resident had on two yellow rings and an yellow watch.</p> <p>Interview with the Director Of Nursing (DON) on 4/22/14 at 1:13 p.m., indicated when a resident is first admitted to the facility an inventory sheet is given to the family to fill out of the residents personal belongings. The DON indicated the CNA's or the nurse will help fill it out.</p> <p>The personal property policy provided by the DON on 4/21/14 at 3:33 p.m., indicated the</p>		<p><b>assure completion of the inventory sheet within 72 hours of admission. IV. The DON/Designee will audit 100% of new admission charts for completed inventory sheets five times a week for 4 weeks, weekly for 4 weeks then monthly thereafter for a total of 12 months. Any identified concerns from audits will be addressed immediately. The results of these audits will be discussed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. COMPLIANCE DATE: 05/16/2014</b></p>				

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	<p>resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished.</p> <p>3.1-50(a)(1)</p>			