

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155822	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/29/2015
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 18275 BURR STREET LOWELL, IN 46356		
(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	
F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: April 21, 22, 23, 24, 27, 28, and 29, 2015</p> <p>Facility number: 013144 Provider number: 155822 AIM number: 201246060</p> <p>Census bed type: SNF: 42 SNF/NF: 4 Residential: 32 Total: 78</p> <p>Census payor type: Medicare: 34 Other: 12 Total: 46</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>This plan of correction is submitted by Cedar Creek health Campus in order to respond to the alleged deficiencies sited during the Annual survey which was conducted in April 2015. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of the Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective May 29, 2015. The facility is requesting a desk review.</p>		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES				

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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Bldg. 00	<p>(INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify a resident's Physician and family/ responsible party of a significant weight loss for 1 of 1 residents reviewed for notification of change. (Resident #45)</p>	F 157	<p>F 157</p> <ol style="list-style-type: none"> Resident #45 family and MD were notified on the weight loss. All residents have the potential to be affected. Weights 	05/29/2015			

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	<p>Finding includes:</p> <p>Resident #45's record was reviewed on 4/23/15 at 1:40 p.m. Diagnoses included, but were not limited to, anemia, pneumonia, iron deficiency, hypokalemia, hyperlipidemia, and end stage renal disease.</p> <p>Review of a written weight log provided by the DHS (Director of Health Services) indicated the following weights: 3/1/15 - 179# 3/6/15 - 169# 3/12/15 - 170.9# 3/20/15 - 161.2# 3/27/15 - 158.5# 4/3/15 - 152.8# 4/17/15 - 141#</p> <p>Calculations indicated the 4/3/15 weight of 152.8# was a 5.2% weight loss in 2 weeks. The 4/17/15 weight of 141# was an 8% loss in 2 weeks and a 12.5% loss in 4 weeks.</p> <p>The Dietary Notes dated 4/2/15 and 4/23/15 lacked documentation to indicate the significant weight losses from 3/20/15 to 4/17/15 were noted or any notification of the Physician or responsible party/ POA were made.</p> <p>A policy titled "Guidelines for Weight</p>		<p>were reviewed to ensure notification was completed as needed</p> <p>3. Licensed Nurses will be re-inserviced on notification of MD and families of change of conditions. DHS or designee will audit 5 charts per week to ensure notification is being completed. DHS or designee will do 5 times per week in Clinical Care Meetings. DHS or designee will report findings monthly to QA&A.</p> <p>4. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed.</p> <p>5. Completion date: May 29, 2015</p>	

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F 242 SS=D Bldg. 00	<p>Tracking" was provided by the Nurse Consultant on 4/28/15 at 11:45 a.m. and deemed as current. The policy indicated, "Purpose: To ensure resident weight is monitored for weight gain and/ or loss to prevent complications arising from compromised nutrition/ hydration ... 8. The physician, responsible party and dietician shall be notified of a weight variance of > 5% (unless on a planned weight loss program)."</p> <p>Interview with the Nurse Consultant on 4/28/15 at 2:25 p.m., indicated the significant weight loss should have been noted and documented by either the staff or the dietician, then the Physician and responsible party made aware per the facility policy.</p> <p>3.1-5(2) 3.1-5(3)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p>						

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	<p>Based on record review and interview, the facility failed to ensure resident's individual preferences were followed, related to not giving a resident a choice of bathing type and the frequency of showers for 2 of 3 residents reviewed for choices of the 6 who met the criteria for choices. (Residents #28 and #65)</p> <p>Findings include:</p> <p>1. Interview with Resident #28 on 4/21/15 at 3:02 p.m., indicated he took showers every week but would prefer to take a tub bath. He further indicated he did not think a tub bath was a choice at the facility.</p> <p>Record review for Resident #28 was completed on 4/28/15 at 9:20 a.m. The Admission MDS (Minimum Data Set) assessment dated 1/21/15, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15. This indicated the resident was cognitively intact. The ADLs (Activities of Daily Living) section indicated the resident required physical help for bathing. The assessment indicated it was very important for the resident to choose between a tub bath, shower, bed bath or sponge bath.</p> <p>A Life Enrichment Assessment Home</p>	F 242	<p>F242</p> <ol style="list-style-type: none"> Resident #28 and #65 preferences were discharged. All residents have the potential to be affected. Resident preferences for bathing have been updated. Nursing were re-inserviced on following the residents preferences. Life Enrichment will be responsible to complete the resident's preference forms within 72 hours. <p>This information will be communicated via electronic Care Tracker. DHS or designee will audit 5 residents per week to ensure preferences are being followed. DHS or designee will report findings to QA&A monthly.</p> <ol style="list-style-type: none"> QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed. Completion date: May 29, 2015 	05/29/2015			

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	<p>Again form was completed on 1/16/15. The Interview for Daily Preferences section indicated it was very important for the resident to choose between a tub bath, shower, bed bath or sponge bath. Tub bath was circled on the form.</p> <p>An Individual Plan Report for ADLs dated 2/10/15, indicated the resident would like to be showered at least two times a week and bathed on all other days.</p> <p>Interview with CNA #3 on 4/28/15 at 10:38 a.m., indicated the resident was supposed to get two showers a week and if he did not want to take a shower he would get washed up at the sink. She further indicated she had never asked him if he would prefer to take a tub bath.</p> <p>Interview with the Life Enrichment Director on 4/28/15 at 10:46 a.m., indicated when residents were admitted they would go over a preference list with them which included bathing preferences. She indicated when the form was completed the answers would be input into the MDS. She further indicated she did not tell nursing about the residents preferences.</p> <p>Interview with MDS Coordinator on 4/28/15 at 10:56 a.m., indicated after the</p>			

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	<p>preference list was filled out in the MDS a care plan was put into place for the residents bathing choices. She further indicated Resident #28's choice for taking a tub bath instead of a shower was missed.</p> <p>2. Interview with Resident #65 on 4/21/15 at 02:48 p. m., indicated, "I would like to take a shower a little more often, I believe they go by a schedule here and I get one about twice a week."</p> <p>Follow up interview with Resident #65 on 4/23/15 at 10:22 a.m., indicated she was never asked how many showers she would like or when and "was told she would get them on Mondays and Thursdays and just accepted that." She further indicated she was not aware she could request more showers.</p> <p>Interview with the MDS (Minimum Data Set) Coordinator on 4/24/15 at 8:50 a.m., indicated the Life Enrichment staff interview the residents regarding preferences upon admission.</p> <p>Interview with Life Enrichment staff #1 on 4/24/15 at 1:20 p.m., indicated the Life Enrichment staff use the Life Enrichment Assessment form to interview residents upon admission, but only ask the questions specified on the form. She further indicated the form does</p>			

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	<p>not include any questions involving bathing frequency preference, only bathing type.</p> <p>Interview with the DHS (Director of Health Services) on 4/24/15 at 1:27 p.m., indicated MDS and Life Enrichment both participate in preferences evaluations. Also, at first conferences, family will occasionally tell staff of a shower frequency preference. She further indicated she was unaware of any facility documentation for resident shower frequency preference.</p> <p>Resident #65's record was reviewed on 4/23/15 at 10:54 a.m.</p> <p>Review of the MDS assessment dated 3/27/15 indicated Resident #65 had a BIMS (Brief Interview of Mental Status) score of 15, which indicated she was cognitively intact.</p> <p>Review of the Life Enrichment Assessment - Home Again dated 1/18/15, indicated it was very important to the resident to choose between a tub bath, shower, bed bath or sponge bath and the resident preferred a shower. The assessment lacked documentation to indicate the resident was asked her preference for how many showers a week she would like to have.</p>			

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F 248 SS=D Bldg. 00	<p>Review of the Bathing Log from 3/29/15 to current indicated Resident #65 had received three complete showers and 19 partial baths in that time.</p> <p>3.1-3(u)(1)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to provide an ongoing activity program designed to meet the needs of a cognitively impaired resident for 1 of 1 residents reviewed for activities. (Resident #57)</p> <p>Finding includes:</p> <p>On 4/22/15 at 8:40 a.m., Resident #57 was observed sitting in his wheelchair by himself outside the main dining room. At 9:32 a.m., he had wheeled himself in front of the nurses' station He was confused and repeatedly banging on and attempting to remove the arm of his</p>	F 248	<p>F248</p> <ol style="list-style-type: none"> Resident #57 was re-assessed for 1:1 activities and to ensure behavior interventions are in place. All residents have the potential to be affected. Residents were reviewed for potential 1:1 activities. Staff was re-inserviced on behaviors interventions. Life enrichment will be re-inserviced on 1:1 activities. Life Enrichment Director or designee will monitor 5 residents per week to ensure they are engaged in activities. Social Service will monitor 5 residents per week to ensure interventions are 	05/29/2015

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	<p>wheelchair, and was not engaged by staff at the desk or offered any diversional activities.</p> <p>On 4/22/15 at 11:05 a.m., the resident was observed sitting in his wheelchair at the end of the main hallway now in the Assisted Living section of the facility. He had backed his wheelchair up into a wall and could not move any further. At 11:36 a.m., he remained alone in his wheelchair in the residential section of the main hallway with his wheelchair backed up against the wall.</p> <p>On 4/22/15 at 11:50 a.m., Resident #57 was observed sitting in his wheelchair in the hallway by the nurses' station, leaning sideways to the right in his chair and appearing to slide forward. Two nurses were sitting at the desk, neither paying attention to the resident until another surveyor went to stand next to the resident and indicated he looked as though he was about to fall out of his chair.</p> <p>Resident #57 was continually observed on 4/23/15 from 8:52 a.m. until 12:52 p.m. At 8:52 a.m., he was sitting at the dining room table alone, staff had just finished assisting him with breakfast. He kept attempting to move his wheelchair backwards, running into other chairs. At</p>		<p>tried when behaviors are being exhibited. Life enrichment director, Social Service Director or designee will report findings to QA&A monthly.</p> <p>4. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed.</p> <p>5. Completion date: May 29, 2015</p>	

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	<p>8:56 a.m., the DHS moved the resident out of the dining area into the main walkway by the Davis Dr. nurses' station. At 9:01 a.m., the resident was observed backing his wheelchair into the therapy room door and the DHS pushed him in his wheelchair down the main hallway back towards the unoccupied Eagle Creek Nurses' station. At 9:20 a.m., the resident remained in his wheelchair by the nurses' station, staff stopped to straighten his sock but no other interaction. The resident kept attempting to back his chair up, but was getting stuck on the wall corner. Between 9:24 a.m. and 9:36 a.m., roughly 5 staff stopped to talk with the resident briefly, but offered no physical intervention related to the resident leaning sideways in his chair or an alternate activity. At 9:28 a.m., staff turned his wheelchair slightly so it was no longer stuck on the corner, but offered no other positioning or interaction. At 9:41 a.m., Resident #57 pushed himself part way down the Eagle Creek hallway. His wheelchair got stuck again on the corner and he continued leaning to the left. Another staff said hello as she continued to walk by. At 9:50 a.m., the Eagle Creek nurse talked to the resident, pushed his wheelchair over to her medication cart in the hallway, and began to prepare his medications. At 9:53 a.m., the Executive Director began talking to</p>			

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	<p>the resident in the hallway, then moved him into his room. At 10:03 a.m., the nurse gave the resident his medications in his room and at 10:07 a.m., a CNA assisted her to reposition him in his wheelchair. At 10:10 a.m., the nurse pushed the resident in his wheelchair back out into the hall by the nurses' station and he resumed wheeling himself around the area unsupervised and with no interaction from staff. At 10:27 a.m., the resident had wheeled himself into the second therapy room, where staff found him and pushed him out of the room and closed the door. A CNA then pushed the resident to the Assisted Living hallway where at 10:30 a.m., Life Enrichment #1 staff took him into the activity room and began reading a book to him. At 11:21 a.m., the resident was observed still sitting in his wheelchair in the activity room with no staff interaction and two staff in the adjoining office, wheeling himself around the room and bumping into other chairs. At 11:36 a.m., Life Enrichment staff wheeled the resident back to the main dining room for lunch. Continued observation at 11:56 a.m., the resident remained by himself at the dining table, playing with his tablecloth and silverware and reaching into his drink for ice. After being assisted with lunch by staff, he was wheeled back into his room at 12:52 p.m. and put to bed.</p>			
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	<p>On 4/23/15 at 1:32 p.m., Resident #57 remained resting in bed, eyes closed, hands slightly fidgety.</p> <p>On 4/24/15 8:36 a.m., Resident #57 was observed sitting in his wheelchair by himself at a table in the main dining room. Continued observation at 8:55 a.m., a CNA wheeled him from the dining room over to therapy, but was told it was not time for therapy currently. She then placed him in his wheelchair in the main hallway between therapy and the main dining room.</p> <p>On 4/24/2015 at 11:43 p.m., Resident #57 was observed sitting in his wheelchair at a table in the main dining room, leaning to the side.</p> <p>On 4/24/2015 at 1:43 p.m., the resident was sitting in his wheelchair in front of a movie near the main dining room and at 3:00 p.m., he was asleep in bed.</p> <p>Resident #57 was continuously observed on 4/27/15 from 8:22 a.m. until 10:12 p.m. At 8:22 a.m., the resident was sitting in his wheelchair at a dining room table, leaning over to his left. Staff was helping another resident at the table, but offered several choices to Resident #57 who refused all suggestions. At 8:45 a.m., he</p>			

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	<p>remained at the table with staff encouraging him to eat. At 9:20 a.m., he had moved to sitting in his wheelchair in the hallway by the nurses' station. He was observed to be agitated and trying to move his wheelchair, which was stuck on the wall corner. His pants were pulled up to knees and he was leaning to the left in chair. At 9:28 a.m., he was moving his wheelchair into the unoccupied secondary therapy room, then out by the kitchenette in the common area. A nurse was sitting at the desk at the nurses' station, not paying attention to the resident. At that time, the DHS walked by with another resident, talked to Resident #57 and attempted to redirect him. He remained in middle of the main hallway. At 9:38 a.m., the DHS wheeled the resident from the main hallway into the ED's office with the ED & another staff member and proceeded to shut the door. At 9:54 a.m., the resident was observed back in the main hallway in his wheelchair in view of the nurses' station. He remained agitated and continually moved around in his wheelchair, ending up by the staff standing by the station. The staff talked to him and rearranged his shirt, but provided no other interaction or diversion. The resident proceeded to wheel himself backwards down the hallway. Activities staff was observed walking up and down the main hallway</p>			

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	<p>during this time with no interaction.</p> <p>Activity staff was not currently observed to be engaged in any activity and nursing staff was present at the station. At 10:00 a. m., the DHS approached the resident in the Eagle Creek hallway, talked to him and asked if he was hungry, to which he said yes. The DHS took him to a dining room table and went to the kitchen to order food. At 10:12 a.m., the resident was observed being assisted with eating in the dining room by the DHS.</p> <p>On 4/27/15 at 12:54 p.m., the resident was observed at the dining room table in his wheelchair after lunch. At 1:16 p.m., he was wheeling and peddling himself forward in his wheelchair all the way down to the Assisted Living (AL) section of the facility with no staff supervision . Continued observation at 1:25 p.m., Life Enrichment staff wheeled the resident back from the far end of the AL hallway and left him in his wheelchair in the main hallway by the second therapy room. The resident proceeded to wheel himself around in the hallway. When he tried to go into the therapy door, staff moved him back to an open area in the main hallway. Two activity staff were observed walking up and down the hallways, asking other residents to come play bingo. At 1:31 p.m., Resident #57 was observed inside the second therapy room in his</p>			

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	<p>wheelchair unattended, almost running into the therapy bars with his head and attempting to reach for them. At 1:33 p.m., a CNA noticed him in the room and wheeled him back out into the Eagle Creek hallway, where he was seen repeatedly running into the end of the open fire door until MDS staff assisted him. At 1:45 p.m., the MDS Coordinator wheeled the resident back into his room, waiting for a CNA to help put the resident in bed.</p> <p>At no time during these observations was the resident engaged in 1:1 activity by staff outside of meals or offered any diversional activities and was observed in the Life Enrichment activity room with staff for less than one hour in the five days noted.</p> <p>Resident #57's record was reviewed on 4/22/15 at 2:01 p. m. Diagnoses included, but were not limited to, severe dementia, diabetes mellitus, Alzheimer's disease and anxiety.</p> <p>A Quarterly MDS (Minimum Data Set) assessment dated 4/9/14 indicated Resident #57 was severely cognitively impaired.</p> <p>First Conference notes dated 1/22/15 indicated issues with mood/ behavior</p>			

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	<p>which included "cognitive deficits, some wandering."</p> <p>An Exit Seeking Circumstance Form dated 1/21/15 at 7:00 pm. indicated, "Res (resident) @ back door, pushing on handle, door didn't open, [increased] wandering in wc (wheelchair). Care Plan: increased wandering. Ck (check) q (every) 15 min x 72 hrs (hours). Wanderguard applied R (right) ankle."</p> <p>A Mental Health Wellness Circumstance Investigation dated 2/1/15 at 12 p.m. indicated, "Type: physical, wandering, repetitive verbalizations. Dx (diagnosis):. dementia. Res refuses vitals. Evaluate medications and change as indicated.</p> <p>A Change in Condition Form dated 2/18/15 at 4 p.m. indicated, "Behavior, new dx.: adjustment disorder w (with)/ mixed anxiety depressed mood. On Lexapro 10 mg (milligrams) S/s (signs/ symptoms): repetitive motions/ behaviors."</p> <p>A Social Services or Physician New or Worsening Behavior Notification dated 3/31/15 at 5:30 a.m. indicated, "Increasing combative behavior, punching, pinching, yelling repetitive, aggressive toward staff, broke CRCA's (certified resident care assistant) glasses.</p>			

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	<p>Current interventions tried: redirection, change in approach, reapproach, calm speech. Monitored x 72 h."</p> <p>Clinically at Risk Monitoring Forms from 1/15/15 to present indicated resident was being monitored weekly for behaviors, frequent falls and nutrition.</p> <p>A Care Plan for moods and behaviors indicated the problem of dementia with episodes of refusing care, wandering and exit-seeking behavior. Interventions included attempt 1:1 (one on one interaction); redirect his attention using validation and life review; assist him to another location; encourage him to get involved in leisure activities, especially when exit-seeking is more prevalent; monitor for sundown syndrome and provide him with activities for diversion.</p> <p>Interview on 4/27/15 at 1:46 p.m. with Life Enrichment staff #1 indicated, for cognitively impaired residents not able to participate in scheduled group activities, staff could try cards or reading to the resident. She indicated there was usually one thing a day they could participate in. She further indicated once a week, staff have "sentimental journey" as a 1:1 approach to reminisce about their life. She also indicated as an example, "Later this afternoon, staff would be doing a</p>			

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	<p>culinary activity which can at least be watched." When a group activity was going on, the activity staff don't have a chance to go out to other rooms. She indicated when she had been working with Resident #57 the other day, she had tried reading to him, coloring & drawing and he wouldn't focus on any of those things.</p> <p>Interview on 4/27/15 at 2:06 p.m. with the DHS (Director of Health Services) indicated Resident #57 was on tracking for behaviors and was also seen by psychiatric services. She further indicated staff "take turns with him on occasion." Staff have tried several things in the past, he does like music. The resident does get agitated wheeling himself around and then starts repetitive mumbling - "I'm sorry ...". The DHS agreed he was care planned for and should have received diversional activities and 1:1.</p> <p>Interview on 4/27/15 at 2:11 p.m. with the Life Enrichment Director, indicated the activity department was supposed to have Sentimental Journeys on Mondays, Wednesdays, and Fridays weekly. Their goal was to try to do it as a group but would do a 1:1 meeting if needed. She was aware Resident #57 was "one who responds to touch, likes looking out the</p>			

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F 279 SS=E Bldg. 00	<p>window in the activity room, loves music and comes to music programs." She further indicated he does have these known interests and "it's a matter of educating the rest of the Life Enrichment staff in finding what works for him." She also indicated Life Enrichment staff charted when a resident came to a group activity, but not any other time spent with a resident.</p> <p>3.1-33(a)</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</p>			

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	<p>§483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop resident care plans, related to dialysis for 1 of 1 residents reviewed for dialysis, antidepressant medications for 1 of 1 residents reviewed for preadmission screening and resident review, and for psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. (Residents #126, #14, #111, and #21)</p> <p>Findings include:</p> <p>1. The record for Resident #126 was reviewed on 4/22/15 at 1:50 p.m. The resident's diagnoses included, but were not limited to, hypertension, acute kidney injury, and atrial fibrillation.</p> <p>Review of the April 2015 Physician Order Summary indicated the resident was to receive dialysis three times a week on Monday, Wednesday, and Friday.</p> <p>Review of the 4/10/15 Admission Minimum Data Set (MDS) assessment indicated the resident had received dialysis.</p> <p>There was a lack of documentation in the record to indicate the resident had a care plan related to dialysis.</p>	F 279	<p>F279</p> <ol style="list-style-type: none"> Resident #126 has been discharged from facility. Resident # 14 Care Plan has been updated concerning medications. Resident # 111 has been discharged from facility. Resident #21 Care Plan was updated to reflect Depression. All residents have the potential to be affected. Care Plans were updated to reflect current status of the residents. IDT has been re-inserviced on ensuring Care Plans are updated to reflect current status of residents. MDS or designee will review 5 charts per week to ensure accuracy with Care Plans. MDS or designee will do reviews in Clinical Care Meetings 5 times per week. MDS or designee will report findings to QA&A monthly. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed. Completion date: May 29, 2015 	05/29/2015

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	<p>Interview with the Minimum Data Set (MDS) Coordinator on 4/28/15 at 10:28 a.m. indicated there was not a care plan for dialysis in place but there should have been.</p> <p>A facility policy, undated, titled, "Guideline for Dialysis Provider Communication," received from the Nurse Consultant as current on 4/23/15 at 3:27 p.m., indicated, "...6. A care plan shall be developed containing the necessary information for ongoing care interventions and approaches regarding Dialysis services."</p> <p>2. The record for Resident #14 was reviewed on 4/23/15 at 11:22 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia with behaviors, and hyperlipidemia.</p> <p>Review of the April 2015 Physician Order Summary indicated the following orders: -Trazodone (an antidepressant medication) 25 mg (milligrams) every night -Risperdal (an antipsychotic medication) 0.25 mg every night as needed</p> <p>Review of the March 2015 and April 2015 Medication Administration Record</p>			

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	<p>(MAR) indicated the resident had received the Trazodone medication daily and the Risperdal medication as needed multiple times.</p> <p>There was a lack of documentation in the record to indicate the resident had a care plan related to the antidepressant and antipsychotic medications.</p> <p>Interview with the Social Service Director on 4/27/15 at 2:20 p.m. indicated there should have been a care plan for the antidepressant and antipsychotic medications.</p> <p>3. Resident #111's record was reviewed on 4/24/15 at 9:20 a.m. The resident's diagnoses included, but were not limited to, anxiety, neuromuscular disorder, and hypertension.</p> <p>Review of the April 2015 Physician Order Summary indicated the following orders: -clonazepam (Klonopin, an antianxiety medication) 0.5 mg (milligrams) twice daily.</p> <p>Review of the 2/20/15 Admission Minimum Data Set (MDS) assessment indicated the resident had received an antianxiety medication.</p>			

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	<p>Review of the March 2015 and April 2015 Medication Administration Record (MAR) indicated the resident had received the clonazepam medication twice daily.</p> <p>There was a lack of documentation in the record to indicate the resident had a care plan related to the antianxiety medication.</p> <p>Interview with the Social Service Director on 4/27/15 at 2:20 p.m. indicated there should have been a care plan for the antianxiety medication.</p> <p>4. Record review for Resident #21 was completed on 4/23/15 at 10:06 a.m. The diagnoses included, but were not limited to, hypertension, diabetes mellitus and depression.</p> <p>The Admission MDS (Minimum Data Set) assessment dated 3/2/15, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 13. This indicated the resident was cognitively intact. The assessment indicated the resident had received an antidepressant 7 times during the 7 day assessment period.</p> <p>A Pre-Admission Screening Program (PAS/PASRR) Assessment Determination for Resident #21 was</p>			

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F 282 SS=E Bldg. 00	<p>completed on 2/16/15. The Level II Health Determination indicated the resident was mentally ill but did not require specialized services. Services of less intensity than specialized services indicated medication monitoring and medication administration.</p> <p>Review of the April 2015 POS (Physician Order Summary), indicated the resident received Paroxetine hcl (depression medication) 20 mg (milligrams) every day for depression.</p> <p>Review of the residents Individual Plan Report did not include a care plan for the depression medication.</p> <p>Interview with MDS Coordinator on 4/23/15 at 1:38 p.m., indicated the resident should of had a care plan in place for the depression medication. She further indicated she would put one into place immediately.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified</p>			

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	<p>persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow physician's orders and care plans, related to proper supervision for bed mobility resulting in a fall with a fracture for 1 of 3 residents reviewed for accidents, laboratory tests for 1 of 5 residents reviewed for unnecessary medications, nutritional supplements and weight loss for 2 of 4 residents reviewed for nutrition, and for activities for a cognitively impaired resident for 1 of 1 residents reviewed for activities. (Residents #112, #14, #45, #57, and #107)</p> <p>Findings include:</p> <p>1. On 4/23/15 at 9:44 a.m. Resident #112 was observed sitting in her wheelchair in the Main Dining Room. The resident had an immobilizer in place to her left upper extremity. The resident was unable to indicate why she had the immobilizer in place.</p> <p>The record for Resident #112 was reviewed on 4/23/15 at 9:36 a.m. The resident's diagnoses included, but were not limited to, hypertension, depression, and dementia.</p> <p>Review of a Fall Circumstance</p>	F 282	<p>F282</p> <p>1. Resident #112 Care Plan was updated to reflect Care with 2 assist. Resident #14 MD was notified of missed labs. Resident #45 MD & family were notified of weight loss. Resident #57 Care Plan has been updated with interventions for behaviors and 1:1 activities. Resident #107 was discharged.</p> <p>2. All residents have potential to be affected. Care plans were updated.</p> <p>3. Nursing staff will be re-inserviced on Care Plan and following Care on the Care Plans, following MD orders, behavior management and ensuring 1:1 is completed. DHS or designee will audit 5 charts per week to ensure compliance with MD notifications, following MD orders; ensuring behavior interventions are being followed. DHS or designee will report findings to QA&A monthly.</p> <p>4. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed.</p> <p>5. Completion date: May 29, 2015</p>	05/29/2015	

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	<p>Assessment and Intervention form dated 4/18/15 7:30 a.m., indicated a CNA had reported assisting Resident #112 with turning in bed and the resident had rolled out of bed. It was further indicated the resident had been sent to the Emergency Room and later returned to the facility with a fracture of the left proximal humerus.</p> <p>Resident #112 had a care plan for ADLS (activities of daily living). The nursing interventions included "...I need 2 assist with all task extensive [sic] -dependent assist with all care..." The resident also had a care plan for risk for falls related to decreased safety awareness, weakness, impaired balance, and need for assistance with transfers/toilet use.</p> <p>Review of the Fall Investigation Follow Up, dated 4/23/15, indicated, "Resident was being rendered care. CNA turned resident on right side to rendered [sic] incontinent care. CNA went to cabinet approx 5 feet away to get wipes. Resident who is obese started to roll forward [sic]. Due to her weight she continued to fall forward off the bed on to the floor. Resident has no safety awareness..."</p> <p>An Employee Counseling Record Form included in the fall follow up, dated</p>			

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	<p>4/20/15, indicated, "...Employee did not follow care plan for resident. Resident fell out of bed and injured herself..."</p> <p>Interview with CNA #3 on 4/24/15 at 11:44 a.m. indicated the resident required assist of 2 with bed mobility and was dependent on staff for all ADLs.</p> <p>Interview with the DHS (Director of Health Services) on 4/24/15 at 2:10 p.m. indicated the resident should have been assisted by 2 CNAs with bed mobility at the time of the fall.</p> <p>2. The record for Resident #14 was reviewed on 4/23/15 at 11:22 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia with behaviors, and hyperlipidemia.</p> <p>Review of the April 2015 Physician Order Summary indicated the following orders: -Zocor (Simvastatin, a cholesterol medication) 20 mg (milligrams) every evening -metoprolol tartrate (Lopressor, a blood pressure medication) 25 mg twice daily -isosorbide mononitrate (Imdur, a heart medication) 30 mg every morning</p> <p>Review of the March 2015 Physician Order Summary indicated the following</p>			

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	<p>laboratory orders: -CBC (complete blood count), BMP (basic metabolic profile, electrolytes) on 3/13/15 -CBC, BMP every Monday x 4</p> <p>Review of a Physician's Order, dated 3/12/15, indicated a lab order for CBC, BMP every Monday x 3, start 3/23/15.</p> <p>Review of the lab results indicated a CBC and BMP had not been completed as ordered on 3/13/15 and 3/23/15.</p> <p>Resident #14 had a care plan for hypertension. The nursing interventions included "...monitor labs as ordered and notify MD/responsible party of results..."</p> <p>Interview with the DHS (Director of Health Services) on 4/28/15 at 11:54 a.m. indicated the labs had not been completed as ordered. She further indicated the resident had multiple lab orders and some of the labs had been missed.3. Resident #45's record was reviewed on 4/23/15 at 1:40 p.m. Diagnoses included, but were not limited to, anemia, pneumonia, iron deficiency, hypokalemia, hyperlipidemia, and end stage renal disease.</p> <p>Review of a written weight log provided by the DHS (Director of Health Services) indicated the following weights:</p>				

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	<p>3/1/15 - 179# 3/6/15 - 169# 3/12/15 - 170.9# 3/20/15 - 161.2# 3/27/15 - 158.5# 4/3/15 - 152.8# 4/17/15 - 141#</p> <p>Calculations indicated the 4/3/15 weight of 152.8# was a 5.2% weight loss in 2 weeks. The 4/17/15 weight of 141# was an 8% loss in 2 weeks and a 12.5% loss in 4 weeks.</p> <p>The Dietary Notes from 4/2/15 and 4/23/15 lacked documentation to indicate the significant weight losses from 3/20/15 to 4/17/15 were noted or any notification of the Physician or responsible party/ POA were made. There were also no interventions in place addressing weight loss.</p> <p>A Care Plan titled "heights/ weights" was reviewed and interventions included, "3/26/15 Weigh me as ordered and monitor my weight trend."</p> <p>Interview with the Nurse Consultant on 4/28/15 at 2:25 p.m., indicated the significant weight loss should have been noted and documented by either the staff or the dietician, then the Physician and responsible party made aware per the</p>						

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	<p>facility policy.</p> <p>4. On 4/22/15 at 8:40 a.m., Resident #57 was observed sitting in his wheelchair by himself outside the main dining room. At 9:32 a.m., he had wheeled himself in front of the nurses' station. He was confused and repeatedly banging on and attempting to remove the arm of his wheelchair, and was not engaged by staff at the desk or offered any diversional activities.</p> <p>On 4/22/15 at 11:05 a.m., the resident was observed sitting in his wheelchair at the end of the main hallway in the Assisted Living section of the facility. He had backed his wheelchair up into a wall and could not move any further. At 11:36 a.m., he remained alone in his wheelchair in the Assisted Living section of the main hallway.</p> <p>On 4/22/15 at 11:50 a.m., Resident #57 was observed sitting in his wheelchair in the hallway by the nurses' station, leaning sideways to the right in his chair and appearing to slide forward. Two nurses were sitting at the desk, neither paying attention to the resident until another surveyor went to stand next to the resident and indicated he looked as though he was about to fall out of his</p>						

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	<p>chair.</p> <p>Resident #57 was continually observed on 4/23/15 from 8:52 a.m. until 12:52 p.m. At 8:52 a.m., he was sitting at the dining room table alone, staff had just finished assisting him with breakfast. He kept attempting to move his wheelchair backwards, running into other chairs. At 8:56 a.m., the DHS moved the resident out of the dining area into the main walkway by the Davis Dr. nurses' station. Throughout the remainder of the observation, the resident was noted moving around in his wheelchair, getting stuck on wall corners and other objects, attempting to go into empty rooms, becoming agitated, and being spoken to by multiple staff briefly, but not offered any other 1:1 or diversional activity. He was taken into the Life Enrichment room once by staff for less than an hour during this time. No other 1:1 was provided.</p> <p>Resident #57 was continuously observed on 4/27/15 from 8:22 a.m. until 10:12 p.m. At 8:22 a.m., the resident was sitting in his wheelchair at a dining room table, leaning over to his left. At 9:20 a.m., he had moved to sitting in his wheelchair in the hallway by the nurses' station. He was observed to be agitated and trying to move his wheelchair, which was stuck on the wall corner. His pants were pulled up</p>			

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	<p>to knees and he was leaning to the left in chair. Throughout the remainder of the observation, he remained agitated and moving throughout the hallways, bumping into things, trying to get into empty rooms, and not engaged by staff. Life Enrichment staff was observed to be walking up and down the hallways at this time and did not engage the resident at all. At 10:00 a.m., the DHS approached the resident in the Eagle Creek hallway, talked to him and asked if he was hungry, to which he said yes. She then took him to a dining room table and went to the kitchen to order food. At 10:12 a.m., the resident was observed being assisted with eating in the dining room by the DHS.</p> <p>On 4/27/15 at 12:54 p.m., the resident was observed at the dining room table in his wheelchair after lunch. At 1:16 p.m., he was wheeling and peddling himself forward in his wheelchair all the way down to the Assisted Living (AL) section of the facility with no staff supervision . Continued observation at 1:25 p.m., Life Enrichment staff wheeled the resident back from the far end of the AL hallway and left him in his wheelchair in the main hallway by the second therapy room. The resident proceeded to wheel himself around in the hallway. When he tried to go into the therapy door, staff moved him back to an open area in the main hallway.</p>			

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	<p>Two activity staff were observed walking up and down the hallways, asking other residents to come play bingo. At 1:31 p.m., Resident #57 was observed inside the second therapy room in his wheelchair unattended, almost running into the therapy bars with his head and attempting to reach for them. At 1:33 p.m., a CNA noticed him in the room and wheeled him back out into the Eagle Creek hallway, where he was seen repeatedly running into the end of the open fire door until MDS staff assisted him. At 1:45 p.m., the MDS Coordinator wheeled the resident back into his room, waiting for a CNA to help put the resident in bed.</p> <p>At no time during these observations was the resident engaged in 1:1 activity by staff outside of meals or offered any diversional activities and was observed in the Life Enrichment activity room with staff for less than one hour in the five days noted.</p> <p>Resident #57's record was reviewed on 4/22/15 at 2:01 p.m. Diagnoses included, but were not limited to, severe dementia, diabetes mellitus, Alzheimer's disease and anxiety.</p> <p>A Care Plan for moods and behaviors indicated the problem of dementia with</p>			

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	<p>episodes of refusing care, wandering and exit-seeking behavior. Interventions included attempt 1:1 (one on one interaction); redirect his attention using validation and life review; assist him to another location; encourage him to get involved in leisure activities, especially when exit-seeking is more prevalent; monitor for sundown syndrome and provide him with activities for diversion.</p> <p>Interview on 4/27/15 at 1:46 p.m. with Life Enrichment staff #1 indicated, for cognitively impaired residents not able to participate in scheduled group activities, staff could try cards or reading to the resident. She indicated there was usually one thing a day they could participate in. She further indicated once a week, staff have "sentimental journey" as a 1:1 approach to reminisce about their life. She also indicated as an example, "Later this afternoon, staff would be doing a culinary activity which can at least be watched." When a group activity was going on, the activity staff don't have a chance to go out to other rooms. She indicated when she had been working with Resident #57 the other day, she had tried reading to him, coloring & drawing and he wouldn't focus on any of those things.</p> <p>Interview on 4/27/15 at 2:06 p.m. with</p>			

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	<p>the DHS (Director of Health Services) indicated Resident #57 was on tracking for behaviors and was also seen by psychiatric services. She further indicated staff "take turns with him on occasion." Staff have tried several things in the past, he does like music. The resident does get agitated wheeling himself around and then starts repetitive mumbling - "I'm sorry ...". The DHS agreed he was care planned for and should have received diversional activities and 1:1.</p> <p>Interview on 4/27/15 at 2:11 p.m. with the Life Enrichment Director, indicated the activity department was supposed to have Sentimental Journeys on Mondays, Wednesdays, and Fridays weekly. Their goal was to try to do it as a group but would do a 1:1 meeting if needed. She was aware Resident #57 was "one who responds to touch, likes looking out the window in the activity room, loves music and comes to music programs." She further indicated he does have these known interests and "it's a matter of educating the rest of the Life Enrichment staff in finding what works for him." She also indicated Life Enrichment staff charted when a resident came to a group activity, but not any other time spent with a resident.</p> <p>5. Record review for Resident #107 was</p>			

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	<p>completed on 4/27/15 at 9:29 a.m. The diagnoses included, but were not limited to, hypertension, diabetes mellitus, anxiety and chronic obstructive pulmonary disease.</p> <p>Review of the residents Individual Plan Report indicated a care plan for Meals/Snacks/Fluids. The care plan was dated 3/26/15 and indicated the resident was following a NAS (No Added Salt) mechanical soft diet and intakes were improving, but weight continued to drop. Interventions included to administer medications and supplements as ordered by the doctor.</p> <p>A Change in Condition Form dated 3/31/15, indicated the resident had a 24.4 lb weight loss over 30 days which equaled 16.9%. The physician was notified and response was for Med Pass 2.0 (nutritional supplement) 120 ml (milliliters) BID (twice a day) between meals for weight stability. Document intake on the MAR (Medication Administration Record).</p> <p>Review of the April 2015 MAR and POS (Physician Order Summary) lacked an order for the Med Pass.</p> <p>Interview with the DHS (Director of Health Services) on 4/27/15 at 1:47 p.m.,</p>			

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F 309 SS=D Bldg. 00	<p>indicated she did the Change of Condition form for the weight loss. She indicated the residents nurse on duty was supposed to do a physicians order and put the supplement on the MAR. She further indicated the order was not completed so it was not put onto the MAR and it should have been.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to a medication not administered as ordered for 1 of 1 residents reviewed for dialysis of the 1 resident who met the criteria for dialysis. (Resident #126)</p> <p>Finding includes:</p> <p>The record for Resident #126 was reviewed on 4/22/15 at 1:50 p.m. The</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> Resident #126 has been discharge. All residents have potential to be affected. Md orders were reviewed to ensure they are being followed. DHS will re-inserviced License nurses on following MD orders. DHS or designee will audit 5 charts per week to ensure following MD orders. DHS or designee will review 	05/29/2015			

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	<p>resident's diagnoses included, but were not limited to, hypertension, acute kidney injury, and atrial fibrillation.</p> <p>Review of a fax from the resident's dialysis center to the RD (Registered Dietician), dated 4/7/15, indicated the resident's phosphorus level was outside the normal range and the resident should be started on Renvela powder, a phosphate binder medication.</p> <p>Review of the Nutrition Progress notes, dated 4/9/15 and 4/16/15 lacked documentation the dialysis centers recommendation for Renvela had been addressed by the dietician.</p> <p>Review of a written prescription, dated 3/7/15, indicated an order for Renvela powder 2.4 g (grams) tid (three times a day).</p> <p>Review of the MAR (Medication Administration Record) for April 2015 lacked documentation the Renvela medication had been administered.</p> <p>Review of the Nurse's Notes, dated late entry 4/20/15 2:30 p.m., indicated "Writer was contacted by (dialysis center) nurse to inquire if resident had started Renevela [sic] powder tid. Writer had the med but it was not administered since</p>		<p>in Clinical Care Meetings 5 times per week. DHS or designee will report findings monthly to QA&A.</p> <p>4. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed.</p> <p>5. Completion date: May 29, 2015</p>	

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F 323 SS=G Bldg. 00	<p>we never had an order. Writer then contacted pharmacy and the order was faxed over to (facility). The order was from the Nephrologist at dialysis...Writer also made dialysis aware that med will be given."</p> <p>Interview on 4/28/15 at 2:26 p.m. with the Nurse Consultant indicated the resident had not received the Renvela medication until 4/21/15 and she was unsure why.</p> <p>3.1-37(a)</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. Based on observation, record review, and interview, the facility failed to ensure proper supervision and assistance was provided with bed mobility for a resident, resulting in a resident falling and obtaining a humerus fracture for 1 of 3 residents reviewed for accidents of the 5 who met the criteria for accidents. (Resident #112)</p> <p>Finding includes:</p>	F 323	<p>F323</p> <ol style="list-style-type: none"> Resident #112 Care Plan had been updated to reflect care. All residents have potential to be affected. Care plans have been updated. Nursing Staffing will be re-inserviced on following Care Plans related to turning and 	05/29/2015

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	<p>On 4/23/15 at 9:44 a.m. Resident #112 was observed sitting in her wheelchair in the Main Dining Room. The resident had an immobilizer in place to her left upper extremity. The resident was unable to indicate why she had the immobilizer in place.</p> <p>The record for Resident #112 was reviewed on 4/23/15 at 9:36 a.m. The resident's diagnoses included, but were not limited to, hypertension, depression, and dementia.</p> <p>Review of 3/5/15 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired and had a fall in the last 2 to 6 months prior to admission. The resident was an extensive assist with a 2 person physical assist for bed mobility.</p> <p>Review of a Fall Circumstance Assessment and Intervention form dated 4/18/15 7:30 a.m., indicated a CNA had reported assisting Resident #112 with turning in bed and the resident had rolled out of bed. It was further indicated the resident had been sent to the Emergency Room and later returned to the facility with a fracture of the left proximal humerus.</p>		<p>repositioning/care. DHS or designee will monitor 5 staff members per week to include all shifts to ensure delivering care as outlined in the Care Plan. DHS or designee will report findings to QA&A monthly.</p> <p>4. QA&A will monitor for any trends monthly for 6 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed. Completion date: May 29, 2015</p>		

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	<p>A hospital imaging result, CR (conventional radiology, x-ray) of the left shoulder, dated 4/18/15 at 9:20 a.m., indicated " Impression: 1. There is an acute, comminuted, mildly displaced fracture of the proximal humerus surgical neck and greater tuberosity..."</p> <p>Resident #112 had a care plan for ADLS (activities of daily living). The nursing interventions included "...I need 2 assist with all task extesive [sic] -dependent assist with all care..." The resident also had a care plan for risk for falls related to decreased safety awareness, weakness, impaired balance, and need for assistance with transfers/toilet use.</p> <p>Review of the PT (physical therapy) - Therapist Progress & Discharge Summary, dated 4/10/15, indicated the resident was able to safely roll from side to side requiring dependent (100% assist).</p> <p>Review of the Fall Investigation Follow Up, dated 4/23/15, indicated, "Resident was being rendered care. CNA turned resident on right side to renderend [sic] incontinent care. CNA went to cabinet approx 5 feet away to get wipes. Resident who is obese started to roll forward [sic]. Due to her weight she continued to fall forward off the bed on</p>			

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NAME OF PROVIDER OR SUPPLIER CEDAR CREEK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 18275 BURR STREET LOWELL, IN 46356
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F 325 SS=D Bldg. 00	<p>to the floor. Resident has no safety awareness..."</p> <p>An Employee Counseling Record Form included in the fall follow up, dated 4/20/15, indicated, "...Employee did not follow care plan for resident. Resident fell out of bed and injured herself..."</p> <p>Interview with CNA #3 on 4/24/15 at 11:44 a.m. indicated the resident required assist of 2 with bed mobility and was dependent on staff for all ADLs.</p> <p>Interview with the DHS (Director of Health Services) on 4/24/15 at 2:10 p.m. indicated the resident should have been assisted by 2 CNAs with bed mobility at the time of the fall.</p> <p>3.1-45(a)(2)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p>			

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	<p>Based on record review and interview, the facility failed to ensure each resident maintained acceptable parameters of nutrition related to monitoring for and identifying a significant weight loss of 12.5% in 4 weeks and not giving a nutritional supplement as ordered for 2 of 4 residents reviewed for nutrition of the 11 who met the criteria for nutrition. (Residents #45 and #107)</p> <p>Findings include:</p> <p>1. Resident #45's record was reviewed on 4/23/15 at 1:40 p.m. Diagnoses included, but were not limited to, anemia, pneumonia, iron deficiency, hypokalemia, hyperlipidemia, and end stage renal disease.</p> <p>Review of a written weight log provided by the DHS (Director of Health Services) indicated the following weights: 3/1/15 - 179# 3/6/15 - 169# 3/12/15 - 170.9# 3/20/15 - 161.2# 3/27/15 - 158.5# 4/3/15 - 152.8# 4/17/15 - 141#</p> <p>Calculations indicated the 4/3/15 weight of 152.8# was a 5.2% weight loss in 2</p>	F 325	<p>F325</p> <ol style="list-style-type: none"> Resident #45 the Dietician notes has been updated. Resident #107 has been discharged from the facility. All residents have the potential to be affected. Dietary notes have been updated on residents. Nursing staff will be re-inserviced on notification of significant weight changes to the dietician. The Dietician will make recommendations as needed. Monthly and weekly weights will be reviewed weekly in Clinical at Risk meetings. Recommendations may be made at that time. DHS or designee will monitor 5 residents per week for compliance of notifications. DHS or designee will report findings to QA&A monthly. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed. Completion date: May 29, 2015 	05/29/2015	

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	<p>weeks. The 4/17/15 weight of 141# was an 8% loss in 2 weeks and a 12.5% loss in 4 weeks.</p> <p>A Dietary Note dated 3/19/15 indicated a significant weight loss of 11% in 30 days was noted after the resident returned from the hospital on 3/17/15 and both the Physician and Power of Attorney/ responsible party were notified.</p> <p>A Dietary Note dated 4/2/15 indicated, "F/u (follow up): Res (resident) area (wound) persists [with] no improvement. REC (recommendation): 1 can qd (daily) nepro (liquid protein supplement) to provide additional 19 g (grams) PRO (protein) to support healing. Intakes @ 78% x 7 d (days). ED (Executive Director) states Res overall has improved. Will continue to monitor & f/u prn (as needed).</p> <p>A Dietary Note 4/23/15 indicated, "F/u: Res continues [with] Remeron (appetite stimulant medication) since 3/19 - REC: d/c (discontinue) r/t (related to) intakes consistent. Continues [with] regular m/s (mechanical soft) diet. Intakes per report 88-93% x 7 d. Nurse stated intakes can vary and depend on res mood. Continues [with] 1 can Nepro qd [with] good intakes. Nurse states res is very good about consuming fluids. Labs: 4/10 glu</p>			

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	<p>(glucose) 66, tot pro 4.9, alb 2.2. REC: Prostat advanced wound care 30 ml qd. may mix [with] beverage of choice to support wound healing. Wound persist and still stg (stage) IV (full thickness). Prostat will provide additional 17 g PRO. Nepro provides 19 g PRO along [with] fort (fortified) foods providing 21 g PRO. Will continue monitoring and f/u prn.</p> <p>The Dietary Notes from 4/2/15 and 4/23/15 lacked documentation to indicate the significant weight losses from 3/20/15 to 4/17/15 were noted or any notification of the Physician or responsible party/ POA were made. There were also no interventions in place addressing weight loss.</p> <p>Review of the Clinically at Risk Monitoring sheets indicated the following:</p> <ul style="list-style-type: none"> - "2/13/15: Res returned 2/10/15, L (left) arm swollen & painful. Res cont (continues) to yell out @ night. Resident's dialysis discontinued. INT (interventions):. 2/13/15 doppler to L arm. Monitor labs, Remeron for appetite. - 3/19/15 Wound/ skin issue. Current status: res readmitted 3/18/15 [after] short hosp (hospital) stay for [low] Hgb (hemoglobin). Res has stage 2 (wound) to coccyx. Tx (treatment) in place. - 3/27/15 weekly f/u: wound exhibits s/s 			

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	<p>(signs/ symptoms) of healing continue current interventions. NP (Nurse Practitioner) to eval. (evaluate) Tx to be evaled.</p> <p>- 4/2/15 Tx as ordered daily. Low air loss mattress. Dietician rec Nepro.</p> <p>- 4/10/15 Wound stage 4. One can Nepro dly (daily) to improve dietary intake. Wound signig (significant) drainage. Abt (Antibiotic - Levaquin x 10 days), cushion to w/c (wheelchair) (Roho)</p> <p>- 4/16/15 stage 4 coccyx. High risk. Ref. (refused) dialysis. Alleviating px [pressure] mattress to bed. Mosiac cushion to w/c."</p> <p>The sheets lacked documentation to indicate the resident was being monitored for weight loss."</p> <p>A Care Plan titled "heights/ weights" was reviewed and interventions included, "3/26/15 Weigh me as ordered and monitor my weight trend."</p> <p>A Care Plan titled "Meals/snacks/fluids" was reviewed. Goals included, " to overall maintain adequate nutrition and hydration with regard to my personal nutrition needs, disease processes and conditions" and interventions included, "3/26/15 I am following a regular mechanical soft diet and continue with appetite stimulant. I have an increased need for protein r/t wound healing so</p>			

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	<p>please make sure I am getting protein at every meal to support healing"</p> <p>A policy titled "Guidelines for Weight Tracking" was provided by the Nurse Consultant on 4/28/15 at 11:45 a.m. and deemed as current. The policy indicated, "Purpose: To ensure resident weight is monitored for weight gain and/ or loss to prevent complications arising from compromised nutrition/ hydration ...3. The facility dietician or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted ... 8. The physician, responsible party and dietician shall be notified of a weight variance of > 5% (unless on a planned weight loss program)."</p> <p>Interview with the Nurse Consultant on 4/28/15 at 2:25 p.m., indicated the significant weight loss should have been noted and documented by either the staff or the dietician, then the Physician and responsible party made aware per the facility policy.</p> <p>2. Record review for Resident #107 was completed on 4/27/15 at 9:29 a.m. The diagnoses included, but were not limited to, hypertension, diabetes mellitus, anxiety and chronic obstructive pulmonary disease.</p>				

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	<p>An MDS (Minimum Data Set) assessment dated 3/27/15, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15. This indicated the resident was cognitively intact. The assessment indicated the resident required supervision of 1 for eating.</p> <p>Review of the residents Individual Plan Report indicated a care plan for Meals/Snacks/Fluids. The care plan was dated 3/26/15 and indicated the resident was following a NAS (No Added Salt) mechanical soft diet and intakes were improving, but weight continued to drop. Interventions included to administer medications and supplements as ordered by the doctor.</p> <p>Review of Resident #107's weight report indicated on 3/5/15 the resident weighed 168.4 lbs (pounds).</p> <p>Review of a Nursing Note dated 3/5/15 at 2:45 p.m., indicated the resident was sent out to the hospital for a psychiatric evaluation.</p> <p>A Nutrition Assessment and Data Collection form dated 3/26/15 indicated the resident was readmitted to the facility on 3/20/15. The residents height was 65</p>			

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	<p>inches and current body weight was 144 lbs. The residents BMI (body mass index) was 24. The residents previous weight within the 30 days was 168.4. The resident had a weight loss of 24.4 lbs within the 30 days (16.9%). The assessment indicated the residents intakes were improving but would not eat everything put in front of her. The resident did not understand why she had lost the weight. The resident had no chewing or swallowing difficulty, but continued to have nausea/GI (gastrointestinal) upset that had been ongoing issue. The resident was willing to try Med Pass (nutritional supplement) to support weight stability. The resident declined for any other nutritional interventions. The assessment indicated the physician and POA (power of attorney) would be notified of a severe weight loss over 30 days.</p> <p>A Change in Condition Form dated 3/31/15, indicated the resident had a 24.4 lb weight loss over 30 days which equaled 16.9%. The physician was notified and response was for Med Pass 2.0 (nutritional supplement) 120 ml (milliliters) BID (twice a day) between meals for weight stability. Document intake on the MAR (Medication Administration Record).</p>						

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	<p>Review of the April 2015 MAR and POS (Physician Order Summary) lacked an order for the Med Pass.</p> <p>The residents weights after the 3/26/15 nutrition assessment were: 3/27/15=148.8 lbs 4/3/15=145.5 lbs 4/13/15=145.5 lbs</p> <p>The resident was discharged from the facility on 4/22/15.</p> <p>Interview with the DHS (Director of Health Services) on 4/27/15 at 1:47 p.m., indicated she did the Change of Condition form for the weight loss. She indicated the residents nurse on duty was supposed to do a physicians order and put the supplement on the MAR. She further indicated the order was not completed so it was not put onto the MAR and it should have been.</p> <p>A policy titled, "Nutrition Recommendation Guideline" was received as current from the Nurse Consultant on 4/29/15 at 12:20 p.m., indicated, "...Guideline: For follow-up on Clinical Nutrition Support (CNS) recommendations...Procedure: 3. CNS reviews recommendations with DHS (Director of Health Services) or designee, and DFS (Director of Food Services), if</p>			

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F 329 SS=D Bldg. 00	<p>possible. If not available, a copy of the recommendation is provided for the ED (Executive Director), DHS, and DFS to review. 4. Suggested discipline follows up on recommendation(s) in a timely manner...."</p> <p>3.1-46(a)(1) 3.1-46(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview,</p>	F 329	F329	05/29/2015	

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	<p>the facility failed to ensure residents were free from unnecessary medications, related to laboratory tests not completed as ordered, an antipsychotic medication given without indications for use, and no prior interventions attempted before the administration of an antipsychotic medication for 2 of 5 residents reviewed for unnecessary medications. (Residents #14, #120)</p> <p>Findings include:</p> <p>1. The record for Resident #14 was reviewed on 4/23/15 at 11:22 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia with behaviors, and hyperlipidemia.</p> <p>Review of the April 2015 Physician Order Summary indicated the following orders:</p> <p>-Zocor (Simvastatin, a cholesterol medication) 20 mg (milligrams) every evening</p> <p>-metoprolol tartrate (Lopressor, a blood pressure medication) 25 mg twice daily</p> <p>-isosorbide mononitrate (Imdur, a heart medication) 30 mg every morning</p> <p>Review of the March 2015 Physician Order Summary indicated the following laboratory orders:</p> <p>-CBC (complete blood count), BMP</p>		<p>1. Resident #14 MD made aware of missing labs. Resident #120 omission of the CMP the MD was notified.</p> <p>2. All residents have the potential to be affected. Labs were reviewed to ensure no others were missed.</p> <p>3. License Nurses will be re-inserviced on following MD orders for labs. DHS or designee will monitor 5 residents per week during Clinical Care Meeting 5 times per week for compliance with following the MD orders. DHS or designee will report findings to QA&A monthly.</p> <p>4. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed.</p> <p>5. Completion date: May 29, 2015</p>		

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	<p>(basic metabolic profile, electrolytes) on 3/13/15 -CBC, BMP every Monday x 4</p> <p>Review of a Physician's Order, dated 3/12/15, indicated a lab order for CBC, BMP every Monday x 3, start 3/23/15.</p> <p>Review of the lab results indicated a CBC and BMP had not been completed as ordered on 3/13/15 and 3/23/15.</p> <p>Resident #14 had a care plan for hypertension. The nursing interventions included "...monitor labs as ordered and notify MD/responsible party of results..."</p> <p>Interview with the DHS (Director of Health Services) on 4/28/15 at 11:54 a.m. indicated the labs had not been completed as ordered. She further indicated the resident had multiple lab orders and some of the labs had been missed.</p> <p>Review of the April 2015 Physician Order Summary indicated an order for Risperdal (risperidone, an antipsychotic medication) 0.25 mg every night as needed.</p> <p>Review of the March 2015 MAR (Medication Administration Record) indicated the resident had received the Risperdal medication on 3/25/15,</p>			

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	<p>3/26/15, 3/27/15, 3/28/15, 3/29/15, and 3/30/15.</p> <p>Review of the Social Services or Physician New or Worsening Behavior Notification form, dated 3/25/15 12:00 a.m. indicated the resident was having multiple behaviors. The behavior follow up charting indicated the following:</p> <ul style="list-style-type: none"> -Follow up on 3/26/15 on the 2 p.m. to 10 p.m. shift indicated the resident had "...no behaviors noted this shift..." -Follow up on 3/27/15 on the 2 p.m. to 10 p.m. shift indicated the resident had no reports of increased agitation or aggression. <p>Review of the PRN (as needed) Medication Tracking form for March 2015 indicated no PRN medications had been administered during the month.</p> <p>Review of the Nurse's Notes for March 2015 lacked documentation of any behaviors, indications for use of the antipsychotic medication, or interventions attempted prior to administering the Risperdal medication on 3/26/15, 3/27/15, 3/28/15, 3/29/15, and 3/30/15.</p> <p>The record lacked documentation of any resident behaviors, indications for use of the antipsychotic medication, or</p>						

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	<p>interventions attempted prior to administering the Risperdal medication on 3/26/15, 3/27/15, 3/28/15, 3/29/15, and 3/30/15.</p> <p>Interview with the DHS (Director of Health Services) on 4/27/15 at 1:50 p.m. indicated interventions should have been attempted and charted on the PRN medication tracking form.</p> <p>A facility policy, dated 8/2013, titled, "Psychotropic Medication Usage and Gradual Dose Reduction," received from the Nurse Consultant as current on 4/23/15 at 3:27 p.m., indicated, "...8. Orders for PRN psychotropic medications will be time limited and designate circumstances for use. a. Administered PRN medications will be documented on the PRN Medication Administration form. 9. Non-pharmacological interventions (such as behavioral interventions) are to be considered and used when indicated, instead of or in addition to, medications. a. Attempted non -pharmacological intervention will be documented on the PRN Medication Administration Form."</p> <p>2. The record for Resident #120 was reviewed on 4/23/15 2:14 p.m. The resident's diagnoses included, but were not limited to, right total knee</p>			

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NAME OF PROVIDER OR SUPPLIER CEDAR CREEK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 18275 BURR STREET LOWELL, IN 46356
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	<p>replacement, osteoarthritis, and venous insufficiency.</p> <p>Review of the April 2015 Physician Order Summary indicated the following orders: -Lasix (furosemide, a diuretic medication) 40 mg (milligrams) daily as needed -K-DUR (potassium) 20 meq (milliequivalents) daily as needed, take when taking Lasix</p> <p>Review of a Physician's Order, dated 4/16/15, indicated a lab order for CBC (complete blood count), CMP (comprehensive metabolic panel, electrolytes) weekly x 4, draw first on Friday 4/17/15 then check every Monday x 3.</p> <p>Review of the lab results indicated the CBC had been completed on 4/20/15 but the CMP had not been completed as ordered.</p> <p>Interview with the DHS on 4/28/15 at 11:54 a.m. indicated the CMP had been missed and had not been completed as ordered.</p> <p>3.1-48(a) 3.1-48(a)(3)</p>			

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F 333 SS=D Bldg. 00	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents were free from significant medication errors related to not giving a medication as ordered to a resident readmitted to the facility after a hospitalization for 1 or 3 residents reviewed for hospitalization of the 5 who met the criteria for hospitalization. (Resident #65)</p> <p>Finding includes:</p> <p>Resident #65's record was reviewed on 4/23/15 at 10:54 a.m. Diagnoses included, but were not limited to, hyperkalemia, renal insufficiency, hypertension, IDDM (insulin dependent diabetes mellitus), anemia, neuropathy, hypercholesterolemia, hypothyroid, reflux, history of abdominal pain and history of rectal bleed.</p> <p>Review of Progress notes dated 2/3/15 indicated, "Received order to send resident to (hospital) ER (emergency room) due to elevated potassium level"</p> <p>Review of Progress Notes dated 2/4/15 indicated, "Admitted to (hospital) Room</p>	F 333	<p>F333</p> <ol style="list-style-type: none"> 1. Resident #65 is discharged from facility. 2. All residents have potential to be affected. MD orders reviewed to ensure they were being followed. 3. Licensed Nurse will be re-inserviced on following MD orders for administration of medications. DHS or designee will monitor random medication pass to include all 3 shifts to ensure compliance. DHS or designee will report monthly findings to QA&A. 4. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed. 5. Completion date: May 29, 2015 	05/29/2015	

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	<p>335. Diagnosis hyperkalemia, dizziness."</p> <p>A History and Physical (H & P) signed by the resident's NP (Nurse Practitioner) on 2/7/15 indicated, "Chief Complaint: 65 y.o. (year old) female readmitted 2-6-15 to C.C. (facility) from (hospital) for hyperkalemia ... Current Diagnosis: 1) Hyperkalemia - resolved current, BMP (basic metabolic panel lab test) every Monday, also on Kayexalate weekly"</p> <p>A Physician's Order dated 2/6/15 indicated, " Kayexalate 30 g (grams) PO (by mouth) weekly on Fridays. BMP q (every) Mon."</p> <p>Review of the MAR (Medication Administration Record) dated to start 2/6/15 indicated, "Kayexalate 30 g PO weekly on Fridays - hyperkalemia."</p> <p>Review of lab results indicated the following potassium (K+) levels (a normal reference range was indicated as 3.7-5.1 meq/L by the lab) 2/3/15 K+ 6.2 C** (critical) 2/9/15 K+ 5.2 H (high) 2/16/15 K+ 5.9 H (high)</p> <p>A handwritten note on the lab result for 2/16/15 indicated, "should be on 30 g Kayexalate Q Fri did [not] get past 2 w (weeks)."</p>			

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	<p>A handwritten note on another copy of the lab result sheet for 2/16/15 indicated, "Send to ER hyperkalemia anemia."</p> <p>A Change in Condition Form dated 2/16/15 at 10 p.m. indicated the reason was abnormal labs, high potassium and low hemoglobin. The treatment was to send to the (hospital) ER.</p> <p>A Resident Transfer Form dated 2/16/15 at 22:30 (10:30 p.m.) from the facility indicated a reason for transfer of low hemoglobin and high potassium.</p> <p>An H & P note from the (hospital) dated 2/17/15 at 6:52 a.m. indicated, "Assessment: 1. anemia of chronic versus acute blood loss. 2. rectal bleeding. 3. Hyperkalemia ... Plan: 1. The patient will be admitted onto general medical floor with telemetry to monitor for change in status. 2. In view of her hemoglobin of 7.1 with dizziness and weakness, we will transfuse her with one unit of packed red blood cells. Check post-transfusion CBC (complete blood count). 3. She does now have a history of GI (gastrointestinal) bleed where she complains of bright red blood per rectum and dark-colored stool. We will be consulting GI to evaluate. She had a colonoscopy done about 3 years ago. 4. Repeat CBC and a CMP</p>			

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	<p>(complete metabolic panel) in the morning. 5. Monitor her potassium closely. Currently it is 5.3. Will repeat value in the a.m.... History of Present Illness: (Resident #65) is a 65 y.o. female patient admitted on 2/16/2015 for CHIEF COMPLAINT: low blood count and hyperkalemia ... She has been evaluated in the emergency room. Repeat potassium was 5.3. Hemoglobin was only at 7.1. She has been admitted under the hospitalist for transfusion and also evaluation of the rectal bleed and treatment of the hyperkalemia. There are no other modifying factors"</p> <p>Interview with the DHS (Director of Health Services) and the Nurse Consultant on 4/24/15 at 2:02 p.m. indicated, when the potassium level came back high on 2/16/15, staff looked back in the resident's chart and noticed the written order for the Kayexalate. It was not placed on the MAR at the time and the medication was not ever given, however it was available. At that time the NP was notified and an incident report filled out. An order was received to send the resident to the ER. The nurse involved was re-educated. The medication was written on the MAR at that time. The DHS further indicated when she spoke with the NP and Physician later, they indicated the low</p>			

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F 502 SS=D Bldg. 00	<p>hemoglobin was at a more critical level than the potassium, resulting in the decision to send the resident to the hospital, where she ended up having hemorrhoid surgery and blood transfusions.</p> <p>3.1-48(c)(2) 3.1-25(b)(9)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on record review and interview, the facility failed to ensure laboratory tests were obtained in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident #118)</p> <p>Finding includes:</p> <p>Record review for Resident #118 was completed on 4/23/15 at 3:05 p.m. The diagnoses included, but were not limited to, heart failure, dementia, and atrial fibrillation.</p> <p>Review of a Physician's Order dated 4/21/15 indicated and order for a UA</p>	F 502	<p>F502</p> <ol style="list-style-type: none"> Resident #118 is discharged from facility. All resident have the potential to be affected. MD orders for labs were reviewed to ensure all were completed. Licensed staff will be re-inserviced on following MD orders for labs. DHS or designee will monitor 5 residents per week to ensure MD orders are being followed. DHS or designee will review labs 5 times per week in Clinical Care Meetings to ensure compliance. DHS or designee will 	05/29/2015

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R 000 Bldg. 00	<p>(urinalysis) with C&S (culture and sensitivity).</p> <p>Review of a Change in Condition form dated 4/22/15 at 1:00 a.m., indicated the resident had increased confusion and lethargy. The physician response indicated to complete a UA with C&S.</p> <p>The residents record lacked information indicating the UA was completed.</p> <p>Interview with LPN #4 on 4/24/15 at 2:23 p.m., indicated she received in report to obtain a UA for the resident today. She further indicated she was unaware he was supposed to of had the UA completed on 4/22/15.</p> <p>Interview with the DHS (Director of Health Services) on 4/24/15 at 2:31 p.m., indicated the resident was supposed to of had a UA completed on 4/22/15 and should have had one completed by now.</p> <p>3.1-49(a)</p> <p>This visit was for a State Residential Licensure Survey.</p>	R 000	<p>report findings monthly to QA&A.</p> <p>4. QA&A will monitor for any trends monthly for 3 months or until 100% compliance is obtained. QA&A will make recommendations to the Plan of Correction as needed.</p> <p>5. Completion date: May 29, 2015.</p> <p>This plan of correction is submitted by Cedar Creek health Campus in order to respond to the alleged deficiencies sited</p>		

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R 090 Bldg. 00	<p>Residential Census: 32</p> <p>Residential Sample: 7</p> <p>Residential Supplemental Sample: 4</p> <p>The following State Residential findings cited is in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency</p> <p>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone</p>		<p>during the Annual survey which was conducted in April 2015. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the position of the Federal and State law. Please accept this plan of correction as the provider's credible allegation of compliance effective May 29, 2015. The facility is requesting a desk review.</p>		

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	<p>number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and</p> <p>(B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on record review and interview, the facility failed to ensure unusual occurrences were reported to the Indiana State Department of Health (ISDH), related to a large bruise and resident to resident altercations for 4 of 9 residents reviewed for abuse and unusual occurrences in a total sample of 7 and a supplemental sample of 4. (Residents #218, #232, #239, and #247)</p>	R 090	R 090 1. Resident # 218 bruise investigation was reported to the state as allegation of abuse. Residents #232 & 242 incident was reported to the state. Resident # 239 incident will be reported to the state on 5/27/15. 2. Incident reports were reviewed for last 30 days to ensure policy related to allegation of abuse is being followed. 3. Staff will re-inserviced on abuse and reporting of incidents. Investigations will be completed	05/29/2015

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	<p>Findings include:</p> <p>1. Resident #218's record was reviewed on 04/23/15 at 10:50 a.m. The resident's diagnoses included, but were not limited to, hypertension and memory loss.</p> <p>A Nurses' Note, dated 03/23/15 at 9:25 p.m., indicated, "...observed a raised 14 cm (centimeter) x (by) 7 cm bruise to Residents (L) (left) wrist area. Bruise purple/blue in color. Res (resident) denied pain...Res unable to recall how she sustained the bruise."</p> <p>A Skin Impairment Circumstance Investigation, dated 03/23/15 at 9:44 p.m., indicated a 14 cm by 7 cm bruise was found on the resident's right wrist.</p> <p>An undated Accident/Incident Report, received from the Executive Director, indicated the probable cause of the bruise was the arm was bumped during a transfer to the toilet.</p> <p>During an interview on 04/23/15 at 12:45 p.m., the Executive Director indicated the bruise had not been reported to the ISDH.</p> <p>2. Resident #232's record was reviewed on 04/23/15 at 11 a.m. The resident's diagnoses included, but were not limited to advanced dementia and behavior</p>		<p>by ED or designee to rule out abuse. ED or designee will be responsible for the report incident in a timely manner. Documented audits will be completed to ensure policy is followed. ED or designee will report finding to QA&A monthly. 4. QA&A will monitor monthly for 3 months or until 100% compliance is obtained for any trends and make recommendations to the plan of correction as needed.</p> <p>Completion date: May 29, 20</p>		

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	<p>disorder.</p> <p>A) A Behavior Notification, dated 02/13/15 at 11 a.m., indicated, "...Accusations by another resident (Resident #247) that this resident became physically aggressive c/ (with) her on 02/12/15 around 8 p.m...."</p> <p>Resident #247's record was reviewed 04/14/15 at 10 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease and dementia.</p> <p>A Nurses' Note, dated 02/13/15 at 10:15 a.m., indicated, "This nurse walked by residents room to hear resident state that she was hit by another resident...Res stated that she was watching movies in living room around 8 p.m. on 02/12/15 when (Resident #232's Name) came up to her c/ (with) hands in a fist...then stated that (Resident #232) hit her in the (L) (left) shoulder hard..."</p> <p>An investigation, dated 02/12/15, no time documented, indicated, "...After staff interviews no witnessed physical contact. (Resident #247) has hx (history) of false accusations. Conclude no physical contact occurred..."</p> <p>B) An Altercation/Concern Circumstance Assessment and</p>				

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	<p>Intervention, dated 03/30/15 at 6:40 p.m., indicated Resident #232 had a resident to resident physical altercation.</p> <p>The Accident/Incident Report, dated 03/30/15 at 6:40 p.m., indicated, " Res (resident) went to (Resident #239) when she came out of her rm (room) et (and) pushed her causing res. (Resident #239) to hit res (Resident #232) in leg c/ cane...Res began to fight over cane when staff intervened..."</p> <p>Resident #239's record was reviewed on 04/24/15 at 11:15 a.m. The resident's diagnoses included, but were not limited to, dementia and hypertension.</p> <p>C) An Altercation/Concern Circumstance, Assessment and Intervention form, dated 04/18/15, no time documented, indicated Resident #232 had a resident to resident physical altercation.</p> <p>An Accident/Incident Report, dated 04/18/15 at approximately 3 p.m., indicated, "...Reported by :(Resident # 218's family)...Reported res (#232) pushed another res (Resident #239) into her room and was smacked by other res (Resident #239)..."</p> <p>An investigation interview, indicated</p>			

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	<p>Resident #232 described the occurrence as,"She hit me in my hands et I don't know why"</p> <p>An investigation interview, indicated Resident #239 described the occurrence as, "I didn't do anything"</p> <p>During an interview on 04/23/15 at 12:45 p.m. the Executive Director indicated the resident to resident physical altercations had not been reported to the ISDH because they were behaviors.</p> <p>A facility policy, titled, "Reportable Event Procedural Guidelines", dated 11/10, and received from the RN (Registered Nurse) Corporate Consultant as current, indicated, " Purpose: To provide guidelines to ensure reportable occurrences are recorded and monitored in accordance with state and federal guidelines. Procedure: Occurrences to be report (sic) include:...b. abuse...e. Injuries of unknown origin...Large lacerations or contusions (of unknown origin or requires hospitalization...)..."</p> <p>A facility policy, titled, "Abuse and Neglect Procedural Guidelines", dated 09/11, and received from the Assistant Director of Health Services as current, indicated, "...The Executive Director and Director of Health Services are</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155822		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/29/2015	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 18275 BURR STREET LOWELL, IN 46356			
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R 302 Bldg. 00	<p>responsible for the implementation and ongoing monitoring of abuse standards and procedures...The Executive Director is accountable for investigating and reporting...Immediately and not more than 24 hours complete an initial report to applicable state agencies..."</p> <p>410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to ensure over the counter medications stored in the medication cart were labeled with the Resident's name and/ or the Physician's name for 1 of 2 medication carts observed.</p> <p>Finding includes: During an observation of the medication cart, with QMA #1 and LPN #2 present, on 04/22/15 at 1:50 p.m., the medication cart had several medication bottles and eye drop bottles of over the counter medications, which had no labels to indicate the Residents nor the Physician's name on the bottles.</p>			R 302	<p>R302</p> <ol style="list-style-type: none"> The medication were labeled per the regulations. Medication carts were reviewed for any other potential lack of labels and corrected at that time. Licensed Staff will be re-inserviced on following regulations of all meds must be label according to the regulatios. DHS or designee will audit for missing labels 3 times per week. Any issues noted will be corrected at that time. DHS 		05/29/2015

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	During an interview at the time of the observation, QMA #1 and LPN #2 indicated the bottles had no labels.		<p>or designee will report findings monthly to QA &A.</p> <p>4. QA&A will monitor monthly for 3 months or until 100% compliance is obtained for any trends and make recommendations to the plan of correction as needed.</p> <p>5. Completion date: May 29, 2015</p>	