STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155701	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 720 E DUSTMAN RD BLUFFTON, IN46714	

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F0000	This visit was for a Recertification and State Licensure survey. Survey Dates: December 6 ,7,8,2011 Facility Number: 000576 Provider Number: 155701 AIM Number: 100267760 Survey Team: Linn Mackey, RN TC Christine Fodrea, RN Timothy Long, RN Julie Wagoner, RN Census Bed Type: SNF: 1 SNF/NF: 64 Residential :30 Total: 95 Census Payor Type: Medicare: 3 Medicaid: 28 Other: 64 Total: 95 Sample: 15 Residential sample: 5 These Deficiencies also reflect state	F0000	This letter and Plan of Correction serve as our **Allegation of Compliance** that by January 6, 2012, Christian Care Retirement Community will have corrected the sited deficiencies and have all of the systemic changes implemented to comply with State and Federal Regulations. We are requesting a paper compliance review of our Plan of Correction instead of an onsite compliance review. Please let us know if this request will be granted.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	findings cited in accordance with 410 IAC 16.2. Quality review completed on December 15, 2011 by Bev Faulkner, RN			

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F0278 SS=B	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurate regarding catheter use for 2 of 2 residents with catheters reviewed in a sample of 15. (Resident #53 and 10) Finding includes: 1. During the initial tour of the facility, conducted on 12/06/11 between 10:45	F0278	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resubmitted Corrected MDS's for residents #53 and #10 on 12/21/11 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	12/21/2011

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	A.M. - 11:20 A.M., LPN #10 indicated Resident #53 was mostly bedfast, received Hospice care, and had a urinary catheter. Resident #53 was observed on 12/07/11 at 9:00 A.M., lying in his bed dressed in a hospital gown. A urinary catheter drainage bag and tubing was noted on the side of his bed, draining clear, yellow urine. The clinical record for Resident #53 was reviewed on 12/06/11 at 9:35 A.M. The Minimum Data Set assessments, completed on 09/07/11 and 11/02/11, indicated the resident was coded "0" or continent of his bladder. Interview with the MDS nurse, on 12/08/11 at 2:30 P.M., indicated she had always coded "0" for residents with urinary catheters and was not aware she should have coded "9" to indicate the resident utilized a urinary catheter.		· Identified all current residents with a catheter and submitted corrected MDS's for 2 of 2 additional residents that had a catheter and incorrect coding on the MDS on 12/21/11 What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · Inserviced MDS nurse on correct coding of the MDS on 12/21/11(Appendix B) · MDS nurse reviewed the RAI manual on the topic · MDS nurse reviewed our practices with an MDS consultant on 12/20/11 · A spreadsheet will be used to track all catheters and MDS answers related to catheter use for 7 months to ensure proper answers on the MDS How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and · MDS's will be audited for 7 months to ensure proper coding by the DON and/or Team Coordinator · DON will monitor audit weekly to ensure all applicable MDS's are audited (Appendix A) · DON will report MDS	

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	2. Resident #10's record was reviewed 12-7-2011 at 9:00 a.m. Resident #10's diagnoses included but were not limited to diabetes, high blood pressure and heart failure. Current physician's orders, dated 12-2011, indicated Resident #10 had an indwelling urinary catheter beginning 8/10/2011. Resident #10's Minimum Data Set (MDS), dated 8-18-2011, indicated Resident #10 did not have an indwelling catheter and had bladder incontinence of less than daily. Additionally, Resident #10's Minimum Data Set, dated 11-16-2011, indicated Resident #10 did not have an indwelling catheter and had bladder incontinence less than daily. In an interview on 12-7-2011 at 11:30 a.m., the Unit coordinator indicated		compliance monthly to the QA team on the status of accurate coding for 7 months following the Plan of Correction approval · QA team will determine if reporting and audit of MDS's must continue or be stopped after 7 months based on compliance of MDS's as shown by catheter and MDS audit spreadsheet By what date the systemic changes will be completed. · 12/21/2011	

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	Resident #10 had an indwelling catheter since her admission to the healthcare unit. Resident #10 was observed on 12-7-2011 at 3:40 p.m., her catheter bag was below her bladder and covered. In an interview on 12-7-2011 at 2:45 p.m., the MDS coordinator indicated the MDS had been coded inaccurately because of information the staff were putting into the computer charting program. A current policy, dated 12-06 and updated 11-11, titled "Resident Assessment Instrument" indicated assessments would be completed accurately as defined by the Centers for Medicare. 3.1-31(d)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to ensure there were care plan initiated for 3 of 15 residents reviewed for care plans in a sample of 15. There were no care plans to address the use of psychiatric medications (Resident #27 and 63), and bowel incontinence needs (Resident #42). Findings include: 1. During the initial tour of the facility, conducted on 12/06/11 between 10:45 A.M. - 11:20 A.M., LPN #10, indicated Resident #42 was usually continent of her bowels and bladder, required moderate staff assistance with toilet needs, and had	F0279	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident #63 had care plans written to address the psychiatric med on 12/21/11 (Appendix F) · Resident #27 passed away on 12/17/11. Resident #27 was not on a psychiatric med on 12/17/11at the time of passing and therefore a care plan to address the psychiatric med could not be updated · Resident #42 had care plan written to address bowel incontinence needs on 12/21/11(Appendix F). The care plan to address bladder incontinence was already in	01/06/2012

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	some behavior issues. The clinical record for Resident #42 was reviewed on 12/07/11 at 9:00 A.M. The resident was admitted to the facility on 10/27/06 with diagnoses including but not limited to, genetic torsion dystonia, depression, and osteoarthritis. Nurses progress notes, dated 08/31/11 at 1:00 P.M., indicated that the resident was incontinent of bowel and bladder. Review of the annual Minimum Data Set (MDS) assessment, completed on 06/14/11, indicated the resident was continent of her bowels. However, the MDS assessment, completed on 11/30/11 indicated the resident had declined and was now frequently incontinent of her bowels (2 or more episodes of bowel incontinence but at least 1 episode of bowel incontinence in the 7 day observation period.) Review of the facility's policy and procedure, titled, "Bowel and Bladder Program, revised 10/99, indicated the following: "Each resident is to have a bowel and bladder assessment completed at the time of admission, annually and at each significant change. The assessment is to be made by the charge nurse with input from the resident, family and nurse aide staff. The assessment is to be		place. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents on psychiatric meds were evaluated to ensure the care plan was in place and updated by 12/21/11. 12 of 12 residents with psychiatric meds had care plans updated to include more personalized interventions. · All residents with bowel or bladder incontinence issues had their care plan for bowel and/or bladder incontinence reviewed as of 12/21/11. 52 of 52 residents with incontinence issues were reviewed to ensure care plans were in place. Care plans will be further updated by 1/6/12 after the new bowel and bladder assessments have been completed to include results of the new assessment. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · A new quarterly bowel and bladder assessment was put into place as of 12/21/11 to re-assess all residents during their quarterly observation and when significant changes occur. 52 of 52 residents with continence issues will be assessed by 1/6/12.	

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	documented on the "Bowel and Bladder Assessment." Toilet habits are entered daily every shift in Care Tracker and used to formulate and modify care plans. Review of the current health care plans for Resident #42, current through 03/06/12, indicated there were no plans to address the resident's bowel incontinence. Interview with the Director of Nursing on 12/08/11 at 9:30 A.M., indicated the MDS was accurate and the resident's care plans had already been revised by 11/30/11. She did not elaborate as to whether a care plan for bowel incontinence should have or was in the process of being written. 2. During the initial tour of the facility, conducted on 12/06/11 between 10:45 A.M. - 11:20 A.M., LPN #10 indicated Resident #63 was confused, had recently had the psychotropic medication, Risperdal, restarted due to delusional behavior. Resident #63 was observed on 12/07/11 from 9:40 A.M. - 11:00 A.M., in the lounge area in a recliner. The resident was noted to be very anxious and restless and repeatedly called various staff members to her and requested assistance to "go home." The resident was not easily		(Appendix I) · A nurse has been appointed as the bowel and bladder nurse responsible for doing and/or reviewing all assessments and ensuring all care plans are updated · A special care plan meeting has been initiated on 12/21/11 to ensure that all psychiatric med and bowel and bladder care plans are updated timely. The DON, MDS coordinator, and Team Coordinator will get together regularly to review incidents, assessments, and physician orders to update care plans accordingly. The meeting will take place every day that the DON, MDS coordinator, and Team Coordinator are scheduled to work. · An in-service with the nurses will take place on 12/27/11 to review updating care plans and the new bowel and bladder assessment. The DON will lead the in-service. (Appendix C and D) · The bowel and bladder program policy has been updated to reflect the changes (Appendix N) · A toileting program spreadsheet has been developed to communicate toileting program changes (Appendix H) · Deficiencies for F279, F280, F309, F315, and F323 are related to care plans and assessments. Therefore, the	

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	redirected or reassured by staff intervention. Staff were noted to repeatedly inform the resident she was "at home" and inform her of the next upcoming activity. The clinical record for Resident #63 was reviewed on 12/06/11 at 9:00 A.M. The resident was readmitted to the facility on 07/18/11 with diagnoses, including but not limited to hallucinations, psychosis with hallucinations an delusions, and dementia. Review of the physician's orders for Resident #63 indicated an order, dated 11/30/11, for the antipsychotic medication, Risperdal 125 mg, at bedtime. Review of the current health care plans for Resident #63, current through 01/19/12, indicated there was no plan to address the resident's delusional behaviors and the use of the Risperdal. In interview on 12/7/2011 at 10:05 a.m., the MDS Coordinator indicated there should have been a careplan initiated for Resident #63 to address her behaviors and use of Risperdal. 3. Resident #27's clinical record was reviewed on 12/6/11 at 11:55 A.M. The record indicated the resident was admitted to the facility on 11/10/11 and had		systemic changes to correct these deficiencies are also related. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and · A checklist will be completed for 7 months to ensure proper updating of care plans by the DON, MDS coordinator, and/or Team Coordinator · DON will monitor checklist weekly to ensure all applicable data is entered into the spreadsheet (Appendix A) · DON will report spreadsheet results monthly to the QA team on the status of care plan updates for 7 months following the Plan of Correction approval · QA team will determine if reporting and tracking of care plans must continue or be stopped after 7 months based on compliance of updated care plans as shown by the care plan tracking spreadsheet By what date the systemic changes will be completed. 1/6/12	

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	diagnoses including, but not limited to, Alzheimer's disease, depression and dysthymic disorder. The resident was admitted with the medication Risperdal (an antipsychotic) 0.25 milligrams at bedtime and continues on the medication. Review of the resident's health care plans did not include a behavior health care plan for the use of Risperdal. An interview with the Social Service Director (SSD) on 12/8/11 at 10:20 A.M., indicated she did not know what the Risperdal was used for. The SSD provided a document on 12/8/11 at 10:20 A.M., from CNA charting, which indicated the resident had no adverse behavioral episodes since admission. An interview with the Director of Nursing (DN) on 12/8/11 at 10:45 A.M., indicated the resident was admitted with Risperdal and she was not sure what type of behavioral episodes the resident was having before she was admitted. The DN indicated the resident should have had a Health Care Plan to address Risperdal use. 3.1-35(a)			

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to ensure fall prevention care plans were updated for 2 of 5 residents reviewed for fall prevention care plans (Resident #17, Resident #3) and care plans for bladder incontinence were updated for 1 of 7 residents reviewed with bladder incontinence care plans. (Resident #63). Findings include: 1. Resident #17's record was reviewed 12-6-2011 at 11:45 a.m. Resident #17's diagnoses included but were not limited to kidney disease, dementia, and anxiety.	F0280	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident #63's care plan was updated and included interventions for toileting on 12/21/11. (Appendix F) The Care plan included a toileting plan based on an hourly schedule determined by voiding patterns. An assessment of the type of bowel and bladder incontinence on the resident was completed so the health care plan could be individualized to restore as much bladder continence as possible. This was completed on 12/23/11.	01/06/2012

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	Resident #17's nurse's notes dated 11-13-2011 at 7:55 p.m. indicated Resident #17 had fallen while standing up from her wheelchair in the hall. The notes further indicated Resident #17 indicated she was looking for the bathroom. The intervention initiated indicated staff were to offer toileting to Resident #17 to prevent further falls. Resident #17's fall prevention care plan dated 11-18-2011 did not indicate to offer toileting to prevent falls. 2.. Resident #3's record was reviewed 12-7-2011 at 2:45 p.m. Resident #3's diagnoses included but were not limited to high blood pressure, depression, and renal failure. Resident #3's nurse's notes dated 11-18-2011 at 11:20 a.m. indicated Resident #3 had fallen while walking independently in his room. The notes further indicated Resident #3 had not utilized his call light to call for assistance. The intervention initiated indicated staff were to closely monitor Resident #3 to prevent further falls. Resident #3's fall prevention care plan dated 10-28-2011 did not indicate to observe closely to prevent falls.		· Resident #17 and #3 care plans were updated for fall interventions on 12/21/11. Resident #17 care plan was updated to include offering toileting as an intervention. Resident #3's care plan was updated to include closely observing resident to prevent falls as an intervention. (Appendix F) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents with bowel or bladder incontinence issues were evaluated to ensure the care plan for bowel and/or bladder incontinence was in place and updated as of 12/21/11 · All residents with a fall in the last 3 months were evaluated to ensure the care plan interventions are updated and in place by 12/21/11 · The therapy department will continue to do a request/screen for rehabilitation assessment on all residents during their quarterly observation which includes a screening of a change in condition to prevent falls. Therapy reviews the screenings weekly at the Fall Risk Meeting with Nursing staff (Appendix G) What measures will be put into place or what systemic changes	

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	In an interview on 12-7-2011 at 9:30 a.m., the lack of careplan updates for Residents #17 and #3 were brought to the attention of the Director of Nursing. The Director of Nursing indicated care plans should be updated to include current interventions. A current policy, dated 4-02 and revised 11-11, titled "Resident Assessment Instrument and Care Planning" indicated each discipline was to transcribe identified problems and interventions to meet a goal.		will be made to ensure that the deficient practice does not recur; · A new quarterly bowel and bladder assessment was put into place as of 12/21/11 to re-assess all residents during their quarterly observation and significant change. This includes evaluating for the appropriateness of a toileting plan. 52 of 52 residents with incontinence issues will be assessed by 1/6/12. (Appendix I) · A new quarterly fall risk assessment was put into place as of 12/21/11 to re-assess all residents during their quarterly observation and significant change. (Appendix J) · The fall/incident investigation report was updated to include required immediate interventions and an update to the care plan if appropriate. This will be completed on all future falls immediately after the fall. This report was updated on 12/21/11 (Appendix K) · A nurse has been appointed as the bowel and bladder nurse responsible for doing and/or reviewing all assessments and ensuring all care plans are updated. Responsibilities of the nurse include evaluating for the appropriateness of a toileting plan · A nurse has been appointed as the falls nurse responsible for doing and/or reviewing all assessments and ensuring all care plans are	

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			updated. Responsibilities of the nurse include evaluating for the appropriateness of interventions after all falls or incidents · A special care plan meeting has been initiated on 12/21/11 to ensure that all fall and bowel and bladder care plans are updated timely. The DON, MDS coordinator, and Team Coordinator will get together regularly to review incidents, assessments, and physician orders to update care plans accordingly. The meeting will take place every day that the DON, MDS coordinator, and Team Coordinator are scheduled to work. · An in-service with nurses on updating care plans and completing assessments is scheduled for 12/27/11. The DON will lead the in-service. (Appendix C and D) · The bowel and bladder program policy has been updated to reflect the changes (Appendix N) · A toileting program spreadsheet has been developed to communicate toileting program changes (Appendix H) · The fall risk protocol has been updated to reflect the changes (Appendix O) · Deficiencies for F279, F280, F309, F315, and F323 are related to care plans and assessments. Therefore, the systemic changes to correct these deficiencies are also	

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	3. During the initial tour of the facility, conducted on 12/06/11 between 10:45 A.M. - 11:20 A.M., LPN #10 indicated		related. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and · A checklist will be completed for 7 months to ensure proper updating of care plans and completion of assessments by the DON, MDS coordinator, and/or Team Coordinator · DON will monitor checklist weekly to ensure all applicable data is entered into the spreadsheet (Appendix A) · DON will report spreadsheet results monthly to the QA team on the status of care plan updates for 7 months following the Plan of Correction approval · QA team will determine if reporting and tracking of care plans and assessments must continue or be stopped after 7 months based on compliance of updated care plans as shown by the care plan tracking spreadsheet By what date the systemic changes will be completed. 1/6/12	

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	Resident #63 was confused, had recently had the psychotropic medication, Risperdal, restarted due to delusional behavior, required total staff assistance for toileting needs, was toileted by staff, and was incontinent of her bowels and bladder. The clinical record for Resident #63 was reviewed on 12/06/11 at 9:00 A.M. The resident was readmitted to the facility on 07/18/11 with diagnoses, including but not limited to hallucinations, psychosis with hallucinations an delusions, and dementia, vertigo, and chronic urinary tract infections. Review of a quarterly Minimum Data Set (MDS) assessment, completed on 10/19/11, indicated the resident had declined in bladder continence and was now always incontinent of her bladder. Review of the current health care plan for urinary incontinence, initiated on 10/19/11, indicated the resident was to be assessed for the proper absorbent product, nursing staff were to apply barrier cream and assist to clean the resident, and the resident was to be checked for incontinence and changed as needed. Review of the documentation indicated part of the time the resident had been			

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	toileted and part of the time she was just changed after having been incontinent. The toileting opportunities were not on an hourly basis and it was unclear how a voiding pattern could have been determined with the type of documentation provided. There was no assessment of the type of bladder incontinency the resident displayed so the health care plan could be individualized to restore as much bladder continence as possible. The health care plan for Resident #63, though initiated on 10/19/11, did not have interventions regarding toileting instructions and only indicated the resident was to be checked for incontinency and changed. 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interviews and record review, the facility failed to follow physician's orders on 2 separate occasions for 1 of 15	F0282	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	12/27/2011

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	residents reviewed for physician's orders in a sample of 15. Resident # 32 Findings include: Resident #32's clinical record was reviewed on 12/6/11 at 2:20 P.M. The record indicated on 10/24/11 a physician's order was received to: increase the resident's Exelon patch from 4.6 milligrams (mg)/24 hours to 9.6 mg/24 hours; increase Risperdal from 0.5 mg twice daily to 0.75 mg twice daily; increase Depakote from 125 mg daily to 125 mg twice daily. Review of the resident's Medication Administration Records (MAR) from October 2011 indicated none of the physician's orders for medication changes on 10/24/11 were implemented. On 10/27/11, physician's orders were received to: keep the Exelon patch at 4.6 mg/24 hours; Depakote 125 mg daily; Risperdal 0.75 mg twice daily. On 11/17/11, a physician's order was received to put Risperdal on hold until 11/22/11 and to reassess and notify the MD. Review of the resident's MAR for		· Resident #32 physician orders were not followed from 11/22 to 11/28 and 10/24 to 10/27 due to the need for clarification. A discussion with the attending physician on 12/19/11 confirmed the future need for a hold order if a similar situation occurs. · Staff received clarification orders on 11/28 and 10/27 and implemented the orders on those dates How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All current orders for all residents have been reviewed to ensure compliance as of 12/21/11 · 63 of 63 residents with orders were reviewed. All of them were in compliance. 1 of the 63 had a current hold order from the physician that was obtained timely. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · A special meeting has been initiated on 12/21/11 to ensure that all physician orders are followed timely. The DON, MDS coordinator, and Team Coordinator will get together regularly to review physician	

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	November 2011 indicated the resident's Risperdal was held from 11/18/11 until 11/28/11 and then the medication was discontinued. No physician order was received to hold or discontinue Risperdal from 11/22/11 through 11/28/11. A physician's order was received on 11/28/11 to discontinue Risperdal. An interview with the Director of Nursing (DN) on 12/7/11 at 9:15 A.M., indicated the medication change orders from 10/24/11 were held as they were waiting for clarification. 3.1-35(g)(2)		orders to ensure immediate implementation. The meeting will take place every day that the DON, MDS coordinator, and Team Coordinator are scheduled to work. · An in-service with nurses on physician holds and clarifications is scheduled for 12/27/11. The DON will lead the in-service. (Appendix E) · A new electronic Emar and Physician Order software is scheduled to be implemented in the facility in February 2012. This new electronic medical record will include checks and balances to ensure all physician orders are followed by sending compliance reports to the DON and Nurses Managers. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and · A checklist will be completed for 7 months to ensure proper updating of physician orders by the DON, MDS coordinator, and/or Team Coordinator · DON will monitor checklist weekly to ensure all applicable data is entered into the spreadsheet (Appendix A) · DON will report spreadsheet results monthly to the QA team on the status of	

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			following physician orders for 7 months following the Plan of Correction approval · QA team will determine if reporting and tracking of physician orders must continue or be stopped after 7 months based on compliance of following physician orders as shown by the tracking spreadsheet By what date the systemic changes will be completed. 12/27/11	
F0309 SS=D	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. Based on record review and interviews, the facility failed to ensure 1 of 1 residents reviewed for incontinence in a sample of 15 was assessed for a decline in bowel continency. (Resident #42) Finding includes: 1. During the initial tour of the facility, conducted on 12/06/11 between 10:45 A.M. - 11:20 A.M., LPN #10 indicated Resident #42 was usually continent of her bowels and bladder, required moderate staff assistance with toileting needs, and had some behavior issues. The clinical record for Resident #42 was	F0309	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident #42 was assessed for a decline in bowel continence on 12/23/11. A care plan was updated to include the results of the assessment (Appendix F) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents with bowel or bladder incontinence issues will be assessed to ensure the care	01/06/2012

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	reviewed on 12/07/11 at 9:00 A.M. The resident was admitted to the facility on 10/27/06 with diagnoses including but not limited to, genetic torsion dystonia, depression, and osteoarthritis. Review of the annual Minimum Data Set (MDS) assessment, completed on 06/14/11, indicated the resident was continent of her bowels. However, the MDS assessment, completed on 11/30/11 indicated the resident had declined and was now frequently incontinent of her bowels (2 or more episodes of bowel incontinence but at least 1 episode of bowel incontinence in the 7 day observation period.). The bowel incontinence assessment was requested on 12/08/11 at 9:00 A.M. Interview with the Director of Nursing, on 12/08/11 at 1:45 P.M., indicated the facility only had toileting data completed by the nursing assistants, but there was no assessment documentation to ensure any causative factors had been assessed and interventions implemented to attempt to help the resident become more continent of her bowels. Review of the facility's policy and procedure, titled, "Bowel and Bladder Program," revised 10/99, indicated the following: "Each resident is to have a		plan for bowel and/or bladder incontinence is in place and updated as of 1/6/12. 52 of 52 residents with incontinence issues will be assessed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · A new quarterly bowel and bladder assessment was put into place as of 12/21/11 to re-assess all residents during their quarterly observation and significant change. 52 of 52 residents will be assessed by 1/6/12. (Appendix I) · A nurse has been appointed as the bowel and bladder nurse responsible for doing and/or reviewing all assessments and ensuring all care plans are updated · A special care plan meeting has been initiated on 12/21/11 to ensure that all bowel and bladder care plans are updated timely. The DON, MDS coordinator, and Team Coordinator will get together regularly to review incidents, assessments, and physician orders to update care plans accordingly. The meeting will take place every day that the DON, MDS coordinator, and Team Coordinator are scheduled to work. · An in-service with nurses on updating care plans and	

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	bowel and bladder assessment completed at the time of admission, annually and at each significant change. The assessment is to be made by the charge nurse with input from the resident, family and nurse aide staff. The assessment is to be documented on the "Bowel and Bladder Assessment." Toilet habits are entered daily every shift in Care Tracker and used to formulate and modify care plans. There was no "Bowel and Bladder Assessment" form presented for Resident #42 in respect to her bowel continency decline. Interview with the DON on 12/08/11 at 9:30 A.M., indicated that the MDS was accurate and the resident's care plans had already been revised by 11/30/11. She did not elaborate as to whether a care plan for bowel incontinence should have or was in the process of being written. 3.1-37(a)		completing assessments is scheduled for 12/27/11. The DON will lead the in-service. (Appendix C and D) · The bowel and bladder program policy has been updated to reflect the changes (Appendix N) · A toileting program spreadsheet has been developed to communicate toileting program changes (Appendix H) · Deficiencies for F279, F280, F309, F315, and F323 are related to care plans and assessments. Therefore, the systemic changes to correct these deficiencies are also related. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and · A checklist will be completed for 7 months to ensure that assessments are being completed by the DON, MDS coordinator, and/or Team Coordinator · DON will monitor checklist weekly to ensure all applicable data is entered into the spreadsheet (Appendix A) · DON will report spreadsheet results monthly to the QA team on the status of care plan updates for 7 months following the Plan of Correction	

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			approval · QA team will determine if reporting and tracking of care plans must continue or be stopped after 7 months based on compliance of assessments as shown by the tracking spreadsheet By what date the systemic changes will be completed. 1/6/12	
F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure a decline in bladder continence was assessed for 1 of 4 residents reviewed for incontinence in a sample of 15. (Resident #63) Finding includes: 1. During the initial tour of the facility, conducted on 12/06/11 between 10:45 A.M. - 11:20 A.M., LPN #10 indicated Resident #63 was confused, had recently had the psychotropic medication, Risperdal, restarted due to delusional behavior, required total staff assistance for toileting needs, and was incontinent of	F0315	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident #63 was assessed for a decline in bladder continence. (Appendix F) A toileting plan was developed based upon an hourly basis by reviewing the voiding pattern from aide documentation. A quarterly bowel and bladder assessment was done which included an analysis of the presence of symptoms of a urinary tract infection. The assessment also includes an analysis of medication changes to determine if they could have had any impact	01/06/2012

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	her bowels and bladder. Resident #63 was observed on 12/07/11 from 9:40 A.M. - 11:00 A.M., in the lounge area in a recliner. The resident was noted to be very anxious and restless and repeatedly called various staff members to her and requested assistance to "go home." The resident was not easily redirected or reassured by staff intervention. Staff were noted to repeatedly inform the resident she was "at home" and inform her of the next upcoming activity. The clinical record for Resident #63 was reviewed on 12/06/11 at 9:00 A.M. The resident was readmitted to the facility on 07/18/11 with diagnoses, including but not limited to hallucinations, psychosis with hallucinations an delusions, and dementia, vertigo, and chronic urinary tract infections. Review of a significant change MDS assessment, completed 07/23/11, indicated the resident had been frequently incontinent (frequently -7 or more episodes of urinary incontinence but at least 1 continent episode in a 7 day observation period). Review of a quarterly Minimum Data Set (MDS) assessment, completed on		on the resident's incontinence. The assessment includes a description of the type of bladder incontinency the resident displayed so the health care plan could be individualized to restore as much bladder continence as possible. This was completed on 12/23/11 · Reviewed and updated policy on UTI assessment as of 12/21/11(Appendix L) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents with bowel or bladder incontinence issues will be assessed to ensure the care plan for bowel and/or bladder incontinence is in place and updated as of 1/6/12. 52 of 52 residents with incontinence issues will be assessed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · A new quarterly bowel and bladder assessment was put into place as of 12/21/11 to re-assess all residents during their quarterly observation and significant change. 52 of 52 residents with continence issues will be assessed by 1/6/12. (Appendix I) · A nurse has been	

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	10/19/11, indicated the resident had declined in bladder continence and was now always incontinent of her bladder. Review of the current health care plan for urinary incontinence, initiated on 10/19/11, indicated the resident was to be assessed for the proper absorbent product, nursing staff were to apply barrier cream and assist to clean the resident, and the resident was to be checked for incontinence and changed as needed. During the daily exit conference, conducted on 12/07/11 at 3:30 P.M., the bladder incontinence assessment for Resident #63 was requested. Interview with the Director of Nursing on 12/08/11 at 10:00 A.M., indicated the facility only utilized the toileting records from the computerized documentation the nursing assistants completed and then reviewed the documentation for "patterns." Review of the documentation indicated part of the time the resident had been toileted and part of the time she was changed after having been incontinent. The toileting opportunities were not on an hourly basis and it was unclear how a voiding pattern could have been determined with the type of		appointed as the bowel and bladder nurse responsible for doing and/or reviewing all assessments and ensuring all care plans are updated · A special care plan meeting has been initiated on 12/21/11 to ensure that all bowel and bladder care plans are updated timely. The DON, MDS coordinator, and Team Coordinator will get together regularly to review incidents, assessments, and physician orders to update care plans accordingly. The meeting will take place every day that the DON, MDS coordinator, and Team Coordinator are scheduled to work. · An in-service with nurses on updating care plans and completing assessments is scheduled for 12/27/11. This in-service will include assessing for UTI's. The DON will lead the in-service. (Appendix C and D and M) · The bowel and bladder program policy has been updated to reflect the changes (Appendix N) · A toileting program spreadsheet has been developed to communicate toileting program changes (Appendix H) · Deficiencies for F279, F280, F309, F315, and F323 are related to care plans and assessments. Therefore, the systemic changes to correct these deficiencies are also	

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	documentation provided. The Director of Nursing indicated the facility's policy did not assess any physical or environmental cause for decline in bladder continence, any presence of symptoms of a urinary tract infection which could impact bladder incontinence, nor was there any documentation medications and medication changes were assessed to determine if they could have had any impact on the resident's incontinence. There was also no assessment of the type of bladder incontinency the resident displayed so the health care plan could be individualized to restore as much bladder continence as possible. Review of the facility's policy and procedure, titled, "Bowel and Bladder Program, revised 10/99, indicated the following: "Each resident is to have a bowel and bladder assessment completed at the time of admission, annually and at each significant change. The assessment is to be made by the charge nurse with input from the resident, family and nurse aide staff. The assessment is to be documented on the 'Bowel and Bladder Assessment.' Toilet habits are entered daily every shift in Care Tracker and used to formulate and modify care plans." There was no "Bowel and Bladder Assessment" form presented for Resident		related. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and · A checklist will be completed for 7 months to ensure that assessments are being completed by the DON, MDS coordinator, and/or Team Coordinator · DON will monitor checklist weekly to ensure all applicable data is entered into the spreadsheet (Appendix A) · DON will report spreadsheet results monthly to the QA team on the status of care plan updates for 7 months following the Plan of Correction approval · QA team will determine if reporting and tracking of care plans must continue or be stopped after 7 months based on compliance of assessments as shown by the tracking spreadsheet By what date the systemic changes will be completed. 1/6/12	

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	#63 in respect to her bladder continence decline. 3.1-41(a)(2)			
F0323 SS=D	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 record review and interview, the facility failed to follow their fall risk protocol policy related to updating or implementing new interventions to prevent further falls for 1 of 5 residents reviewed with history of falls in the sample of 15. Resident # 17 Findings included:	F0323	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · Resident #17's fall care plan was updated to offer toileting as an intervention. Furthermore, there were additional personalized interventions added to prevent falls put into place on the care plan. (Appendix F). The update was complete on 12/21/11 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; · All residents with a fall in the last 3 months were evaluated to ensure the care plan interventions are updated and in place by 12/21/11 · The therapy department will continue to do a request/screen for rehabilitation assessment on all residents during their quarterly observation	12/27/2011

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			which includes a screening of a change in condition to prevent falls. Therapy reviews the screenings weekly at the Fall Risk Meeting with Nursing staff (Appendix G) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; · A nurse has been appointed as the falls nurse responsible for doing and/or reviewing all assessments and ensuring all care plans are updated. Responsibilities of the nurse include evaluating for the appropriateness of interventions after all falls or incidents · A new quarterly fall risk assessment was put into place as of 12/21/11 to re-assess all residents during their quarterly observation and significant change. (Appendix J) · The fall/incident investigation report was updated to include required immediate interventions and an update to the care plan if appropriate. This will be completed on all future falls immediately after the fall. This report was updated on 12/21/11 (Appendix K) · A special care plan meeting has been initiated on 12/21/11 to ensure that all fall care plans are updated timely. The DON, MDS coordinator, and Team Coordinator will get	

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			together regularly to review incidents, assessments, and physician orders to update care plans accordingly. The meeting will take place every day that the DON, MDS coordinator, and Team Coordinator are scheduled to work. · An in-service with nurses on updating care plans and completing assessments is scheduled for 12/27/11. The DON will lead the in-service. (Appendix C and D) · The bowel and bladder program policy has been updated to reflect the changes (Appendix N) · A toileting program spreadsheet has been developed to communicate toileting program changes (Appendix H) · The fall risk protocol has been updated to reflect the changes (Appendix O) · Deficiencies for F279, F280, F309, F315, and F323 are related to care plans and assessments. Therefore, the systemic changes to correct these deficiencies are also related. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and · A checklist will be completed for 7 months to ensure	

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			proper updating of care plans by the DON, MDS coordinator, and/or Team Coordinator · DON will monitor checklist weekly to ensure all applicable data is entered into the spreadsheet (Appendix A) · DON will report spreadsheet results monthly to the QA team on the status of care plan updates for 7 months following the Plan of Correction approval · QA team will determine if reporting and tracking of care plans must continue or be stopped after 7 months based on compliance of updated care plans as shown by the care plan tracking spreadsheet By what date the systemic changes will be completed. 12/27/11	
	Resident #17's record was reviewed 12-6-2011 at 11:45 a.m. Resident #17's diagnoses included but were not limited to kidney disease, dementia, and anxiety. Resident #17's nurse's notes, dated 11-13-2011 at 7:55 p.m., indicated Resident #17 had fallen while standing up from her wheelchair in the hall. The notes further indicated Resident #17 indicated she was looking for the bathroom. The intervention initiated indicated staff were to offer toileting to Resident #17 to			

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	prevent further falls. Resident #17's fall prevention care plan, dated 11-18-2011, did not indicate to offer toileting to prevent falls. Resident #17's nurse's notes indicated she fell out of bed on 11-16-2011 at 3:40 p.m. There were no immediate or new interventions to prevent falls put into place. Resident #17's nurse's notes indicated she fell 11-16-2011 at 8:35 p.m., while propelling herself down the hall in her wheelchair. There were no immediate or new interventions to prevent falls put into place. Resident #17's nurse's notes indicated she fell out of bed on 11-16-2011 at 9:05 p.m. There were no immediate or new interventions to prevent falls put into place. Resident #17's nurse's notes indicated she fell out of her recliner on 11-16-2011 at 11:00 p.m. There were no immediate or new interventions to prevent falls put into place. Resident #17's nurse's notes indicated she fell out of bed on 11-19-2011 at 4:00 a.m. There were no immediate or new			

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	interventions to prevent falls put into place. A current policy, dated 9-06 and revised 12-11 titled Fall risk protocol indicated immediate safety precautions were to be put into place at the time of each fall. In an interview on 12-7-2011 at 1:45 p.m., the Director of Nursing indicated the facility staff should be updating fall care plans with new interventions after each fall. 3.1-45(a)(2)			