

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155264	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE	STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 7, 8, 9, 13, 14, 15, and 16, 2015</p> <p>Facility number: 000165 Provider number: 155264 AIM number: 100288220</p> <p>Census bed type: SNF/NF: 116 Total: 116</p> <p>Census payor type: Medicare: 19 Medicaid: 84 Other: 13 Total: 116</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review by 30576 on October 21, 2015.</p>	F 0000		
F 0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT			

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>ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation</p>	F 0225	F225/226 The corrective actions accomplished for those residents found to have been	11/11/2015			

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	<p>of abuse, was immediately reported to the Indiana State Department of Health (ISDH) Long Term Care and was thoroughly investigated. (Resident #112 and Resident #150)</p> <p>Findings include:</p> <p>The clinical record of resident #150 was reviewed on 10-13-15 at 3:00 p.m. A clinical progress note, signed by the Alzheimer's Care Unit Director and dated 7-28-15 at 5:39 p.m., indicated the resident's daughter, "Reported to nursing staff that she thought she saw a male peer have his hand inside [name of Resident #150's] shirt in the sunroom yesterday afternoon. She said upon entrance to the sunroom male peer did move away from [name of Resident 150] and left the area. Writer did meet with both [name of Resident 150] and male peer. When asked if something had happened, [name of Resident 150] nodded her head and said, 'Yes, something happened,' and with one hand she waved in front of her shirt indicating her chest area with a slight smile on her face. Writer asked her what happened and she said, 'I was touched.' She was unable to tell writer who touched her, but did say that she did not tell him no [sic] and she denied feeling scared or afraid. Writer did explain to her in simple terms to alert staff if she</p>		<p>affected by the deficient practice are as follows: Resident #150 discharged home with family as planned on 10-2-2015. Resident #112 care plan was updated to include inappropriate comments and behaviors. No other alleged inappropriate behavior has occurred since 7-28-2015. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Residents were interviewed regarding their rights to be free of abuse and what this means, also the need for reporting such incidents. No residents had any incident to report nor had they witnessed any type of incident. Sign posted on Alzheimer's care unit for staff to notify Supervisor of any needs or request for privacy or intimacy immediately. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Education on Abuse/Unusual Occurrences Reporting and Investigation was provided to Managers on 10/29/15 and all staff on 11/3/15. Newly hired employees will continue to be educated on Abuse/Unusual Incidents. Posters regarding reporting serious events/unusual occurrences will be placed at each of the public/staff entrances. ED will ensure that posters are visible and readable.</p>	

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	<p>she [sic] was ever touched inappropriately. She nodded her head in agreement. Writer did then meet with [name of Resident 150's] daughter and she stated that she believed [name of Resident 150] was likely the aggressor as [name of Resident 150] 'Likes men and likes to flirt' and 'She has no sexual filter of what is right and wrong anymore.' Writer explained that this sometimes happen with dementia and staff would monitor. She was pleased."</p> <p>In an interview with the Alzheimer's Care Unit Director on 10/13/2015 at 3:09 p.m., she indicated she recalled the incident involving Resident #150 and the male peer, Resident #112. She indicated she was the one who did the investigation of the incident. She indicated, "Looks like I didn't put a follow up note." She indicated she met with both residents individually. She indicated Resident #112 continues to reside on the unit. She indicated the male peer denied anything happened. "The daughter indicated she 'thought' it had happened, but wasn't exactly sure what happened, if anything. Like my note said, the daughter said she wouldn't be surprised if her mother wasn't the instigator, if anything did happen. The female resident indicated something happened as in the chest area, but could not tell me any details. [Name</p>		<p>Resident Council will receive education around what is and reporting abuse/unusual occurrences and the education will be reported in the notes. ED will monitor to ensure this takes place.</p> <p>Education on Abuse/Unusual Occurrences reporting and investigation was provided to Managers on 10/29/15 and all staff on 11/3/15. Last annual in-service on abuse/unusual occurrences was March 2015 and the ED will ensure that this in-servicing occurs in the first half of the year in 2016.</p> <p>The ED/DNS or their designee will monitor through A.M. Reporting for any incident that may fall under the reporting and investigation and will ensure compliance. ED/DNS will report any non-compliance to the QAPI meeting.</p> <p>This deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 months. QAPI results will determine if monitoring and extended education are needed.</p>		

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	<p>of Resident #112] didn't recall anything." She indicated she spoke to the family of Resident #112 to inform them of the situation. The Alzheimer's Care Unit Director indicated "...I didn't do a[n ISDH] reportable...I will say that there was no harm that came to either resident."</p> <p>In an interview with the Executive Director (ED) on 10-13-15 at 4:15 p.m., he indicated he was aware of the incident with Resident #112 and Resident #150. He indicated the facility staff discussed "what to do with this particular case. We wanted to make sure we were honoring their Resident Rights, but still make sure we were being cautious. We didn't really view this as an abuse situation. We did not file a reportable with ISDH. We took into consideration that she was care planned as being somewhat flirtatious and the daughter's statement that she was not 100% sure of what she saw or did not see, as well as the daughter saying that if anything did take place, her mother may have been the instigator. There were no more episodes of any interactions between the two residents." In a second interview with the ED on 10/14/2015 at 1:27 p.m., he indicated the Alzheimer's Care Unit Director informed him and the Director of Nursing (DON) immediately of the incident.</p>			

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F 0226 SS=D	<p>On 10-16-15 at 11:05 a.m., the ED provided a copy of a policy entitled, "Reporting Alleged Abuse Violation," with a review date of 1-15-15, and was indicated to be the current policy in use by the facility. This policy indicated, "It is the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation property ('alleged violation') are reporting [sic] immediately to the executive director of the center. Such violations are also reported to state agencies in accordance with existing state law. The center investigates each such alleged violation thoroughly and reports the result of all investigations to the executive director or his or her designee, as well as to state agencies as required by state and federal law."</p> <p>3.1-28(d) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT,</p>			

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Bldg. 00	<p>ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to follow the facilities policy and procedures on reporting and investigating an allegation of abuse. (Resident #112 and Resident #150)</p> <p>Findings include:</p> <p>The clinical record of resident #150 was reviewed on 10-13-15 at 3:00 p.m. A clinical progress note, signed by the Alzheimer's Care Unit Director and dated 7-28-15 at 5:39 p.m., indicated the resident's daughter, "Reported to nursing staff that she thought she saw a male peer have his hand inside [name of Resident #150's] shirt in the sunroom yesterday afternoon. She said upon entrance to the sunroom male peer did move away from [name of Resident 150] and left the area. Writer did meet with both [name of Resident 150] and male peer. When asked if something had happened, [name of Resident 150] nodded her head and said, 'Yes, something happened,' and with one hand she waved in front of her shirt indicating her chest area with a slight smile on her face. Writer asked her what happened and she said, 'I was touched.'</p>	F 0226	<p>F225/226 The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Resident #150 discharged home with family as planned on 10-2-2015. Resident #112 care plan was updated to include inappropriate comments and behaviors. No other alleged inappropriate behavior has occurred since 7-28-2015. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Residents were interviewed regarding their rights to be free of abuse and what this means, also the need for reporting such incidents. No residents had any incident to report nor had they witnessed any type of incident. Sign posted on Alzheimer's care unit for staff to notify Supervisor of any needs or request for privacy or intimacy immediately. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Education on Abuse/Unusual Occurrences Reporting and Investigation was provided to Managers on</p>	11/11/2015

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	<p>She was unable to tell writer who touched her, but did say that she did not tell him no [sic] and she denied feeling scared or afraid. Writer did explain to her in simple terms to alert staff if she she she [sic] was ever touched inappropriately. She nodded her head in agreement. Writer did then meet with [name of Resident 150's] daughter and she stated that she believed [name of Resident 150] was likely the aggressor as [name of Resident 150] 'Likes men and likes to flirt' and 'She has no sexual filter of what is right and wrong anymore.' Writer explained that this sometimes happen with dementia and staff would monitor. She was pleased."</p> <p>In an interview with the Alzheimer's Care Unit Director on 10/13/2015 at 3:09 p.m., she indicated she recalled the incident involving Resident #150 and the male peer, Resident #112. She indicated she was the one who did the investigation of the incident. She indicated, "Looks like I didn't put a follow up note." She indicated she met with both residents individually. She indicated Resident #112 continues to reside on the unit. She indicated the male peer denied anything happened. "The daughter indicated she 'thought' it had happened, but wasn't exactly sure what happened, if anything. Like my note said, the daughter said she</p>		<p>10/29/15 and all staff on 11/3/15. Newly hired employees will continue to be educated on Abuse/Unusual Incidents. Posters regarding reporting serious events/unusual occurrences will be placed at each of the public/staff entrances. ED will ensure that posters are visible and readable.</p> <p>Resident Council will receive education around what is and reporting abuse/unusual occurrences and the education will be reported in the notes. ED will monitor to ensure this takes place.</p> <p>Education on Abuse/Unusual Occurrences reporting and investigation was provided to Managers on 10/29/15 and all staff on 11/3/15. Last annual in-service on abuse/unusual occurrences was March 2015 and the ED will ensure that this in-servicing occurs in the first half of the year in 2016.</p> <p>The ED/DNS or their designee will monitor through A.M. Reporting for any incident that may fall under the reporting and investigation and will ensure compliance. ED/DNS will report any non-compliance to the QAPI meeting.</p> <p>This deficient practice was addressed during monthly QAPI meeting and will be monitored monthly x 6 months. QAPI results will determine if monitoring and extended education are needed.</p>				

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	<p>wouldn't be surprised if her mother wasn't the instigator, if anything did happen. The female resident indicated something happened as in the chest area, but could not tell me any details. [Name of Resident #112] didn't recall anything." She indicated she spoke to the family of Resident #112 to inform them of the situation. "I am so sorry, but, I cannot believe I didn't do a[n ISDH] reportable. That's part of my job. I will say that there was no harm that came to either resident."</p> <p>In an interview with the Executive Director (ED) on 10-13-15 at 4:15 p.m., he indicated he was aware of the incident with Resident #112 and Resident #150. He indicated the facility staff discussed "what to do with this particular case. We wanted to make sure we were honoring their Resident Rights, but still make sure we were being cautious. We didn't really view this as an abuse situation. We did not file a reportable with ISDH. We took into consideration that she was care planned as being somewhat flirtacious and the daughter's statement that she was not 100% sure of what she saw or did not see, as well as the daughter saying that if anything did take place, her mother may have been the instigator. There were no more episodes of any interactions between the two residents." In a second</p>			

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	<p>interview with the ED on 10/14/2015 at 1:27 p.m., he indicated the Alzheimer's Care Unit Director informed him and the Director of Nursing (DON) immediately of the incident.</p> <p>Review of the progress notes in the week that followed the incident for Resident #150, only one follow up note was located. On 7-29-15 at 12:55 a.m., the entry indicated she was "pleasant with staff on this shift. No mood or behavior concerns noted at this time...No distress noted."</p> <p>On 10-16-15 at 11:05 a.m., the ED provided a copy of a policy entitled, "Reporting Alleged Abuse Violation," with a review date of 1-15-15, and was indicated to be the current policy in use by the facility. This policy indicated, "It is the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property...It is also the policy of this center to take appropriate steps to ensure that all alleged violations of federal or state laws which involve mistreatment, neglect, abuse, injuries of unknown source and missappropriation property ('alleged violation') are reporting immediately to the executive director of the center. Such violations are also</p>			

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F 0272 SS=D Bldg. 00	<p>reported to state agencies in accordance with existing state law. The center investigates each such alleged violation thoroughly and reports the result of all investigations to the executive director or his or her designee, as well as to state agencies as required by state and federal law."</p> <p>3.1-28(a)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;</p>			

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	<p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure residents residing on the Alzheimer's Care Unit had an accurate comprehensive assessment of their functional capacity documented, using the Minimum Data Set (MDS) in order to establish plans of care for 2 of 22 residents reviewed for assessments and plans of care. (Resident #112 and Resident #148)</p> <p>Findings include:</p> <p>A. Resident #112's clinical record was reviewed on 10/15/2015 at 10:31 a.m. It indicated his diagnoses included, but were not limited to, strokes and vascular dementia. It indicated he resided on the secured Alzheimer's Care Unit. An admission nursing assessment, dated 5-22-15 indicated the resident was alert with short term memory problems, with long term memory "ok", his cognitive skills were "independent, reasonable, consistent." A quarterly nursing assessment, dated 8-28-15, indicated Resident #112 was alert with short term</p>	F 0272	<p>POC 97- 10/16/15 F272 SS=D</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice is as follows: Res #112 and Res #148 comprehensive assessments were completed And currently up to date by RNAC and MDS Asst. Care plans were audited and reflect current condition. Other residents having the potential to be affected by the alleged deficient practice will be identified and the corrective actions taken are as follows: All other resident charts and MDS assessments were audited by Nursing Mgmt. and found to be in compliance with admission comprehensive assessments and care plans. RNAC and MDS staff who were hired after date of deficiency have had extensive training from Corporate to ensure education. The measures put into place and the systemic changes made to ensure that this alleged deficient practice does not recur are as follows: All new admission will be checked during 72hr meeting to ensure assessments are accurate and in the chart by RNAC/MDS Asst/ or designee .</p>	11/11/2015

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	<p>memory problems, but the long memory was "ok." It indicated he required assistance with decision-making. Review of the psychiatrist's progress note, dated 8-29-15, it indicated the resident was alert and oriented to name and place, but not to time or name of the facility.</p> <p>The initial MDS, dated 6-4-15, indicated his cognition status was not assessed by an interview with the resident or the staff. The following MDS assessment, dated 9-4-14, indicated he was cognitively intact as assessed by resident interview. Review of the 6-4-15, "Care Assessment Assessment Summary (CAAS)" indicated the section for cognition did not trigger for care plan development. A care plan related to cognition was not initiated until 8-25-15.</p> <p>In an interview with LPN #2 on 10-13-15 at 3:09 p.m., she indicated, that due to his strokes, he tends to respond slowly to any questions. She indicated in the last month or so, he will use more words to get his wants and needs known. She indicated he initially mostly gestured to get his needs known.</p> <p>In an interview with LPN #1 on 10-14-15 at 10:33 a.m., she indicated Resident #112's cognition "seems to come and go. It's like some days, he just cannot finds</p>		<p>to include cognition, vision, mood behavior, psychosocial well-being, physical functioning, continence, disease diagnosis, dental and nutritional status, skin, Activity, medications, special treatments, and procedure. No MDS will be completed without resident or staff interview. All admission Clinical Health Assessment forms were placed into plastic sleeves and noted "Do Not Remove from Chart" All Nurse Management staff and Alzheimer's Care Director were in-serviced 10/29/15.</p> <p>DNS/ADNS/or designee will audit charts upon admission to ensure appropriate coding is complete with IPOC to reflect the individual.</p> <p>Chart audits will be monitored by the DNS, Medical Records and/or the DNS designee. The medical record will be audited for timeliness, thoroughness, and completeness on admission, at significant changes, per MDS schedule, and quarterly review, with any trend of non-compliance being reported by the DNS/designee to the monthly QAPI meeting.</p> <p>These corrective actions will be monitored and a quality assurance program implemented to ensure the corrective actions accomplished to prevent the alleged deficient practice from recurring: DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written</p>				

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	<p>his words and will gesture. [He] seems to have problems with short term memory. Some days he seems more able to interact [with others]."</p> <p>In an interview with the Executive Director (ED) on 10/14/2015 at 9:34 a.m., he indicated earlier this year, "We lost both our MDS Coordinator and her assistant. We had a contractual MDS person for a short while, prior to the [current] MDS Coordinator coming on board for the MDS position. So there could be some coding issues. But I personally cannot answer for the reason the BIMS [Brief Interview for Mental Status assessment] was not assessed for [name of Resident #112's] admission MDS."</p> <p>In an interview with the MDS Coordinator on 10/14/2015 at 9:47 a.m., she indicated, "We realize that during the time that we had an interim MDS person, things may not have gotten done as well as we would like. We are working diligently to get those issues rectified. I have been here only a short time. But, like I said, we are working on getting things improved."</p> <p>In an interview with the ED on 10/14/2015 at 1:27 p.m., he indicated the person who conducted the admission</p>		and interventions implemented	

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	<p>MDS for Resident #112 was from a sister facility and was unavailable for interview at this time.</p> <p>In an interview with the Director of Nursing (DON) on 10-16-15 at 11:23 a.m., she indicated she could not locate a specific policy on care plan development. " But here is what we are supposed to be doing. When a resident first comes in, depending on their Clinical Health Status, or the Admission Nursing Assessment, an immediate plan of care is developed by the nursing staff. Then, depending on what is on that first page of the Nursing Assessment form, [related to] cognition or psych meds, Social Services will develop a care plan for those areas. Then, when the MDS staff completes the admission MDS, they will develop care plans for the areas that trigger on the MDS. For any acute issues, like a UTI [urinary tract infection] or pneumonia, the nursing staff should be developing an acute care plan. The care plan should be updated at least quarterly or with a significant change in the resident's status."</p> <p>B. Resident #148's clinical record was reviewed on 10-14-15 at 3:00 p.m. It indicated her diagnoses included, but were not limited to, dementia, macular degeneration and low back pain. It</p>			

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	<p>indicated she resided on the secured Advanced Alzheimer's Care Unit of the facility.</p> <p>Review of Resident #148's admission Minimum Data Set (MDS) assessment, dated 5-4-15, indicated she had short term and long term memory problems, was severely cognitively impaired, required extensive assistance of one or more persons for bed mobility, transfers, dressing, toileting and hygiene. She required extensive assistance of one person for moving about on the unit or off of the unit or eating. She rarely walked, but when she did, she required the assistance of two persons to do so. She used a wheelchair or walker for mobility. She was frequently incontinent of bowel and bladder. Review of the 5-4-15, "Care Assessment Assessment Summary (CAAS)," indicated the "ADL [activities of daily living] Functional/Rehabilitation Potential" section did not trigger for care plan development. It indicated the "Urinary Incontinence and Indwelling Catheter" and "Cognitive Loss/Dementia" sections did trigger for care plan development.</p> <p>Review of Resident #148's care plans indicated there were no care plans developed for ADL assistance. A care plan related to dementia was initiated on</p>			

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	<p>8-4-15. A care plan was initiated on 10-15-15 related to incontinence of her bowel and bladder.</p> <p>In an interview with CNA #3 on 10/13/2015 at 11:50 a.m., she indicated Resident #148 was able to feed herself with very little cueing required, was ordered to receive thickened liquids, and seemed to tolerate that well without any coughing, was incontinent of bowel and bladder and required total care with toileting.</p> <p>In an interview with a family member of Resident #148 on 10-15-15 at 12:10 p.m., she indicated the resident was "totally incontinent" and wears an incontinent brief.</p> <p>In an interview with the MDS Assistant Coordinator on 10/15/2015 at 3:24 p.m., she indicated, "If an area triggers under the CAAS, the system will not allow you to un-trigger it. If an area triggers under the CAAS, you cannot complete the MDS until the area until it is addressed in some manner. I have no idea why the ADL's did not trigger for her, because they should have. I will notify IT [technical support] to find out why it didn't." She indicated one of the MDS staff members participates in all care plan meetings. She indicated, "We will</p>			

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	<p>review the current care plans and try to do a 'big picture' look at the resident and the resident's needs. So, we can adjust, add or remove any care plans at that time.</p> <p>In an interview on 10/15/2015 at 3:47 p.m., with the MDS Assistant Coordinator, she indicated she was unable to locate a care plan for urinary incontinence.</p> <p>On 10-15-15 at 11:45 a.m., the Alzheimer's Care Unit Director provided a copy of a CNA assignment form which included information for Resident #148's care needs. This form indicated she required extensive to total assistance, used a wheelchair and occasionally required the use of a mechanical lift for transfers.</p> <p>In an interview on 10/16/2015 at 11:45 a.m. with the Assistant Director of Nursing, she indicated the CNA Assignment sheets are not considered a permanent part of the clinical record.</p> <p>In an interview with the Executive Director (ED) on 10/14/2015 at 9:34 a.m., he indicated earlier this year, "We lost both our MDS Coordinator and her assistant. We had a contractual MDS person for a short while, prior to the [current] MDS Coordinator coming on board for the MDS position. So there</p>			

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	<p>could be some coding issues."</p> <p>In an interview with the MDS Coordinator on 10/14/2015 at 9:47 a.m., she indicated, "We realize that during the time that we had an interim MDS person, things may not have gotten done as well as we would like. We are working diligently to get those issues rectified. I have been here only a short time. But, like I said, we are working on getting things improved."</p> <p>In an interview with the Director of Nursing (DON) on 10-16-15 at 11:23 a.m., she indicated she could not locate a specific policy on care plan development. " But here is what we are supposed to be doing. When a resident first comes in, depending on their Clinical Health Status, or the Admission Nursing Assessment, an immediate plan of care is developed by the nursing staff. Then, depending on what is on that first page of the Nursing Assessment form, [related to] cognition or psych meds, Social Services will develop a care plan for those areas. Then, when the MDS staff completes the admission MDS, they will develop care plans for the areas that trigger on the MDS. For any acute issues, like a UTI [urinary tract infection] or pneumonia, the nursing staff should be developing an acute care plan. The care</p>			

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F 0279 SS=E Bldg. 00	<p>plan should be updated at least quarterly or with a significant change in the resident's status."</p> <p>3.1-31(a) 3.1-31(c)(3) 3.1-31(c)(4) 3.1-31(e)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview the facility failed to develop care plans that addressed: a resident's dental status (Resident #95), diuretic use (Residents #2 and #38), use of a blood</p>	F 0279	F279 SS=E The corrective actions accomplished for those residents found to have been affected by the deficient practice as follows: Resident #95, #2, #38, #60, #112 and #148 care plans were immediately updated	11/11/2015

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	<p>thinner (Resident #60), activities of daily living and urinary incontinence (Resident #112 and #148) . This affected 6 of 22 residents reviewed for care development.</p> <p>Findings include:</p> <p>1. Resident #95's record was reviewed on 10/14/15 at 11:02 a.m. Current physician's orders indicated Resident #95 had diagnoses that included, but were not limited to, high blood pressure, Alzheimer's disease, chronic airway obstruction, esophageal reflux, senile dementia, respiratory abnormalities, stroke, and anxiety. The physician's orders also indicated the resident received a regular, no added salt diet.</p> <p>An initial oral assessment, dated 6/20/13, indicated Resident #95 had no teeth and only had dentures.</p> <p>An Annual Minimum Data Set (MDS) assessment, dated 5/10/15, indicated Resident #95 had no natural teeth or tooth fragments, had no facial pain, discomfort, or difficulty with chewing and no problems with eating or swallowing. The Care Area Assessment (CAA) Summary indicated dental care would be included in the care planning decision and indicated the CAA triggered due to dental problem of no teeth, and</p>		<p>to reflect current status. Other residents having the potential to be affected by the alleged deficient practice will be identified and the corrective actions taken are as follows: Facility audit was done by DNS/ADNS/Unit Spvrs/MDS/RNAC/and ACD. All care plans were reviewed and updated to reflect current status of all Residents in the facility. To include, dental status, diuretic use, anticoagulants, And continence. The measures put into place and the systemic changes made to ensure that this alleged deficient practice does not recur are as follows: DNS/ADNS/designee will audit charts upon admission to ensure immediate plans of care are initiated to include cognition, vision, mood behavior, psychosocial well-being, physical functioning, continence, disease diagnosis, dental and nutritional status, skin, Activity, medications, special treatments, and procedure. Care plan team will review care plans upon admission at 72hr meeting to ensure all of the above mentioned are care planned. All care plans will be reviewed during quarterly assessment and change of condition. These corrective actions will be monitored and a quality assurance program implemented to ensure the corrective actions accomplished to prevent the alleged deficient practice from recurring:</p>				

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	<p>that it was addressed in the care plan.</p> <p>A care plan dated 5/12/15, indicated a focus of: "I am at risk for decline in ADL (activities of daily living) function r/t (related to) advancing effects of Alzheimer's/dementia. Goal: All of my ADL needs will be met on a daily basis, thru next assessment.</p> <p>Interventions...Assist with oral care BID and PRN (as needed)--has dentures...."</p> <p>Review of all of Resident #95's care plans failed to indicate a care plan that addressed her not wearing her dentures.</p> <p>On 10/7/15, at 4:52 p.m., Resident #95 indicated she has a beautiful pair of dentures but chooses not to wear them. Resident #95 was observed at that time not wearing dentures, and had no natural teeth.</p> <p>During an interview, on 10/14/15 at 11:12 a.m., RN #6 indicated Resident #95 has no problems eating, chewing, or swallowing, and he has never seen her with dentures. Review of her inventory sheet with RN #6 failed to indicate dentures were listed on the inventory sheet.</p> <p>On 10/15/15, at 3:46 p.m., the MDS Assistant indicated there was no care plan</p>		<p>Chart audits will be monitored by the DNS, Medical Records and/or the DNS designee. The medical record will be audited for timeliness, thoroughness, and completeness on admission, at significant changes, per MDS schedule, and quarterly review, with any trend of non-compliance being reported by the DNS/designee to the monthly QAPI meeting.</p> <p>DNS/Designee will report findings of audits to monthly QA meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented. lished to prevent the alleged deficient practice from recurring:</p>		

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	<p>for Resident #95 related to her dentures.</p> <p>On 10/14/15, at 3:19 p.m., the Director of Nursing indicated a staff member found a full set of dentures in Resident #95's room.</p> <p>2. Review of Resident #38's record indicated diagnoses included but were not limited to dementia with behavioral disturbance, post-traumatic stress disorder, chronic, delusional disorder, vascular dementia with behavioral disturbance, heart failure, cardiomyopathy, nonrheumatic aortic valve disorders, essential hypertension, chronic ischemic heart disease and generalized edema.</p> <p>Physician's recapitulation orders dated October 1, 2015, indicated Lasix 60 mg by mouth in the morning related to congestive heart failure, start date 11/21/14.</p> <p>Lasix 40 mg by mouth in the afternoon related to congestive heart failure unspecified, start date 11/20/14.</p> <p>Review of Minimum Data Set (MDS) annual assessment dated July 17, 2015, indicated Medications Received - diuretic 7 days.</p> <p>No care plan was found for the use of the</p>			

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	<p>diuretic.</p> <p>10/15/15 at 2:15 p.m., Director of Nursing presented care plan for Resident #38 indicated Focus: Potential for alteration in hydration related to: diuretic use for my history of cardiomyopathy and congestive heart failure. Date initiated:10/15/15.</p> <p>Goal: Patient will remain free of signs/symptoms fluid deficit: decreased urine output, concentrated urine, poor skin turgor, dry mucus membranes, confusion, hypotension, tachycardia, headache, fatigue/weakness, dizziness, fever, thirst, weight loss. Date initiated: 10/15/15, revision on 10/15/15, target date: 12/31/15.</p> <p>Interventions: Administer diuretic per physician orders, observe for side effects. Date initiated: 10/15/15. Check vital signs and auscultate breath sounds as needed, more frequently if indicated. Date initiated: 10/15/15. Encourage rest periods as needed. Date initiated: 10/15/15. Medicate per physician orders for fever, nausea, vomiting, diarrhea. Date initiated: 10/15/15. Monitor weight per physician order, notify physician of weight gain/loss. Date initiated: 10/15/15.</p> <p>Observe appearance of mucus membranes,skin turgor. Date initiated: 10/15/15.</p>			

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	<p>Observe for mental status changes/mood and behavior changes. Date initiated: 10/15/15. Obtain and monitor lab/diagnostic work per physician order. Report results to physician and follow up as needed. Date initiated: 10/15/15.</p> <p>3. Review of Resident #2's record indicated diagnoses included but were not limited to major depressive disorder, recurrent, severe with psychotic symptoms, edema, unspecified, presence of cardiac pacemaker, unspecified right bundle-branch block, presence of unspecified artificial knee joint, chronic ischemic heart disease.</p> <p>Physician's recapitulation orders dated October 1, 2015, indicated Lasix 20 mg give 1 tablet in morning every other day related to edema, start date 9/14/13.</p> <p>Review of Minimum Data Set (MDS) quarterly assessment dated August 29, 2015, indicated Medications Received - diuretic 4 days.</p> <p>No care plan found in Resident #2's record for the use of the diuretic.</p> <p>10/15/15 at 2:15 p.m., Director of Nursing presented care plan for Resident #2 indicated Focus: Potential for alteration in hydration related to: diuretic</p>			

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	<p>use for my history of edema, heart disease and hypertension. Date initiated:10/15/15.</p> <p>Goal: Patient will remain free of signs/symptoms fluid deficit: decreased urine output, concentrated urine, poor skin turgor, dry mucus membranes, confusion, hypotension, tachycardia, headache, fatigue/weakness, dizziness, fever, thirst, weight loss. Date initiated: 10/15/15, revision on 10/15/15, target date: 12/31/15.</p> <p>Interventions: Administer diuretic per physician orders, observe for side effects. Date initiated: 10/15/15. Check vital signs and auscultate breath sounds as needed, more frequently if indicated. Date initiated: 10/15/15. Encourage rest periods as needed. Date initiated: 10/15/15. Medicate per physician orders for fever, nausea, vomiting, diarrhea. Date initiated: 10/15/15. Monitor weight per physician order, notify physician of weight gain/loss. Date initiated: 10/15/15.</p> <p>Notify physician of signs/symptoms fluid excess/fluid deficit. Date initiated: 10/15/15. Observe appearance of mucus membranes,skin turgor. Date initiated: 10/15/15. Observe for mental status changes/mood and behavior changes. Date initiated: 10/15/15. Obtain and monitor lab/diagnostic work per physician order. Report results to</p>			

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	<p>physician and follow up as needed. Date initiated: 10/15/15.</p> <p>4. Review of Resident #60 record indicated diagnoses included but were not limited to, Alzheimer's disease, unspecified atrial fibrillation, bipolar disorder, unspecified, hyperlipidemia and hypokalemia.</p> <p>Physician's recapitulation orders dated October 1, 2015, indicated Coumadin 4 mg give 1 tablet in the evening related to atrial fibrillation, start date 9/28/15.</p> <p>Review of Minimum Data Set (MDS) quarterly assessment dated July 22, 2015 indicated Medications Received - anticoagulant 6 days.</p> <p>No care plan found for the use of the anticoagulant.</p> <p>10/15/15 at 2:15 p.m., Director of Nursing presented care plan for Resident #2 indicated Focus: At risk for complications to anticoagulant or antiplatelet medication due to heart disease and hypertension. Date initiated: 10/15/15.</p> <p>Goal: Will remain without complications from bleeding or injury. Date initiated: 10/15/15. Revision on: 10/15/15. Target</p>			

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	<p>date 12/31/15. Interventions: Apply prolonged pressure to venipuncture sites. Date initiated: 10/15/15. Monitor dietary intake of foods high in vitamin K (green leafy vegetables). Date initiated: 10/15/15. Monitor medication regime medications which increase effects. Date initiated: 10/15/15. Observe for adverse reaction: fever, skin lesions, anorexia, nausea, vomiting, cramps, diarrhea, hemorrhage, hemoptysis. Date initiated: 10/15/15. Observe for signs/symptoms of bleeding i.e., tarry stools, blood in urine, bruising, petechiae. Date initiated: 10/15/15. Obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated. Date initiated: 10/15/15. Utilization of soft bristle toothbrush and inspect oral cavity for ulcerations or bleeding gums. Date initiated: 10/15/15.</p> <p>10/15/15 3:26 p.m., interview with Minimum Data Set Coordinator indicated she did an audit on the care plans for Resident #38 and Resident #2's diuretic medication and Resident #60's anticoagulant medication and "they weren't there, so I created them today."</p> <p>5. Resident #112's clinical record was reviewed on 10/15/2015 at 10:31 a.m. It indicated his diagnoses included, but were not limited to, strokes and vascular dementia. It indicated he resided on the</p>			

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	<p>secured Alzheimer's Care Unit. An admission nursing assessment, dated 5-22-15 indicated the resident was alert with short term memory problems, with long term memory "ok", his cognitive skills were "independent, reasonable, consistent." A quarterly nursing assessment, dated 8-28-15, indicated Resident #112 was alert with short term memory problems, but the long term memory was "ok." It indicated he required assistance with decision-making. Review of the psychiatrist's progress note, dated 8-29-15, it indicated the resident was alert and oriented to name and place, but not to time or name of the facility.</p> <p>The initial MDS, dated 6-4-15, indicated his cognition status was not assessed by an interview with the resident or the staff. The following MDS assessment, dated 9-4-14, indicated he was cognitively intact as assessed by resident interview. Review of the 6-4-15, "Care Assessment Assessment Summary (CAAS)" indicated the section for cognition did not trigger for care plan development. A care plan related to cognition was not initiated until 8-25-15.</p> <p>In an interview with LPN #2 on 10-13-15 at 3:09 p.m., she indicated, that due to his strokes, he tends to respond slowly to any</p>			

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	<p>questions. She indicated in the last month or so, he will use more words to get his wants and needs known. She indicated he initially mostly gestured to get his needs known.</p> <p>In an interview with LPN #1 on 10-14-15 at 10:33 a.m., she indicated Resident #112's cognition "seems to come and go. It's like some days, he just cannot finds his words and will gesture. [He] seems to have problems with short term memory. Some days he seems more able to interact [with others]."</p> <p>In an interview with the Executive Director (ED) on 10/14/2015 at 9:34 a.m., he indicated earlier this year, "We lost both our MDS Coordinator and her assistant. We had a contractual MDS person for a short while, prior to the [current] MDS Coordinator coming on board for the MDS position. So there could be some coding issues. But I personally cannot answer for the reason the BIMS [Brief Interview for Mental Status assessment] was not assessed for [name of Resident #112's] admission MDS."</p> <p>In an interview with the MDS Coordinator on 10/14/2015 at 9:47 a.m., she indicated, "We realize that during the time that we had an interim MDS person,</p>			

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	<p>things may not have gotten done as well as we would like. We are working diligently to get those issues rectified. I have been here only a short time. But, like I said, we are working on getting things improved."</p> <p>In an interview with the ED on 10/14/2015 at 1:27 p.m., he indicated the person who conducted the admission MDS for Resident #112 was from a sister facility and was unavailable for interview at this time.</p> <p>In an interview with the Director of Nursing (DON) on 10-16-15 at 11:23 a.m., she indicated she could not locate a specific policy on care plan development. " But here is what we are supposed to be doing. When a resident first comes in, depending on their Clinical Health Status, or the Admission Nursing Assessment, an immediate plan of care is developed by the nursing staff. Then, depending on what is on that first page of the Nursing Assessment form, [related to] cognition or psych meds, Social Services will develop a care plan for those areas. Then, when the MDS staff completes the admission MDS, they will develop care plans for the areas that trigger on the MDS. For any acute issues, like a UTI [urinary tract infection] or pneumonia, the nursing staff should be</p>			

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	<p>developing an acute care plan. The care plan should be updated at least quarterly or with a significant change in the resident's status."</p> <p>6. Resident #148's clinical record was reviewed on 10-14-15 at 3:00 p.m. It indicated her diagnoses included, but were not limited to, dementia, macular degeneration and low back pain. It indicated she resided on the secured Advanced Alzheimer's Care Unit of the facility.</p> <p>Review of Resident #148's admission Minimum Data Set (MDS) assessment, dated 5-4-15, indicated she had short term and long term memory problems, was severely cognitively impaired, required extensive assistance of one or more persons for bed mobility, transfers, dressing, toileting and hygiene. She required extensive assistance of one person for moving about on the unit or off of the unit or eating. She rarely walked, but when she did, she required the assistance of two persons to do so. She used a wheelchair or walker for mobility. She was frequently incontinent of bowel and bladder. Review of the 5-4-15, "Care Assessment Assessment Summary (CAAS)," indicated the "ADL [activities of daily living] Functional/Rehabilitation Potential"</p>			

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	<p>section did not trigger for care plan development. It indicated the "Urinary Incontinence and Indwelling Catheter" and "Cognitive Loss/Dementia" sections did trigger for care plan development.</p> <p>Review of Resident #148's care plans indicated there were no care plans developed for ADL assistance. A care plan related to dementia was initiated on 8-4-15. A care plan was initiated on 10-15-15 related to incontinence of her bowel and bladder.</p> <p>In an interview with CNA #3 on 10/13/2015 at 11:50 a.m., she indicated Resident #148 was able to feed herself with very little cueing required, was ordered to receive thickened liquids, and seemed to tolerate that well without any coughing, was incontinent of bowel and bladder and required total care with toileting.</p> <p>In an interview with a family member of Resident #148 on 10-15-15 at 12:10 p.m., she indicated the resident was "totally incontinent" and wears an incontinent brief.</p> <p>In an interview with the MDS Assistant Coordinator on 10/15/2015 at 3:24 p.m., she indicated, "If an area triggers under the CAAS, the system will not allow you</p>			

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	<p>to un-trigger it. If an area triggers under the CAAS, you cannot complete the MDS until the area until it is addressed in some manner. I have no idea why the ADL's did not trigger for her, because they should have. I will notify IT [technical support] to find out why it didn't." She indicated one of the MDS staff members participates in all care plan meetings. She indicated, "We will review the current care plans and try to do a 'big picture' look at the resident and the resident's needs. So, we can adjust, add or remove any care plans at that time. In an interview on 10/15/2015 at 3:47 p.m., with the MDS Assistant Coordinator, she indicated she was unable to locate a care plan for urinary incontinence.</p> <p>On 10-15-15 at 11:45 a.m., the Alzheimer's Care Unit Director provided a copy of a CNA assignment form which included information for Resident #148's care needs. This form indicated she required extensive to total assistance, used a wheelchair and occasionally required the use of a mechanical lift for transfers.</p> <p>In an interview on 10/16/2015 at 11:45 a.m. with the Assistant Director of Nursing, she indicated the CNA Assignment sheets are not considered a</p>			

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	<p>permanent part of the clinical record.</p> <p>In an interview with the Executive Director (ED) on 10/14/2015 at 9:34 a.m., he indicated earlier this year, "We lost both our MDS Coordinator and her assistant. We had a contractual MDS person for a short while, prior to the [current] MDS Coordinator coming on board for the MDS position. So there could be some coding issues."</p> <p>In an interview with the MDS Coordinator on 10/14/2015 at 9:47 a.m., she indicated, "We realize that during the time that we had an interim MDS person, things may not have gotten done as well as we would like. We are working diligently to get those issues rectified. I have been here only a short time. But, like I said, we are working on getting things improved."</p> <p>In an interview with the Director of Nursing (DON) on 10-16-15 at 11:23 a.m., she indicated she could not locate a specific policy on care plan development. " But here is what we are supposed to be doing. When a resident first comes in, depending on their Clinical Health Status, or the Admission Nursing Assessment, an immediate plan of care is developed by the nursing staff. Then, depending on what is on that first page of</p>			

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	<p>the Nursing Assessment form, [related to] cognition or psych meds, Social Services will develop a care plan for those areas. Then, when the MDS staff completes the admission MDS, they will develop care plans for the areas that trigger on the MDS. For any acute issues, like a UTI [urinary tract infection] or pneumonia, the nursing staff should be developing an acute care plan. The care plan should be updated at least quarterly or with a significant change in the resident's status."</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2) 3.1-35(c)(1) 3.1-35(d)(1) 3.1-35(d)(2) 3.1-35(d)(2)(A) 3.1-35(d)(2)(B)</p>			