

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/18/2013
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NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November, 12, 13, 14, 15 and 18, 2013</p> <p>Facility number: 000081 Provider number: 155162 AIM number: 100289570</p> <p>Survey Team: Toni Maley, BSW, TC Karen K Koberlein, RN Angela Selleck, RN (11/12/13, 11/14/13, 11/15/13 & 11/18/13) Shelley Reed, RN</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 8 Medicaid: 41 Other: 15 Total: 64</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora</p>	F000000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after December 18, 2013. We respectfully request a desk review in lieu of a post survey revisit.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Barth, RN.			

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F000166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on interview and record review, the facility failed to make prompt efforts to resolve a resident's grievance regarding staffs word choices when providing toileting assistance for 1 of 12 residents interviewed regarding facility practices (Resident #9).</p> <p>Findings include:</p> <p>1.) During an 11/13/13, 12:44 p.m., interview, Resident #9 indicated she had experienced a recent interaction with a CNA when she was not treated respectfully. Resident #9 indicated a "CNA had asked me if she could see my butt." She indicated she told the nurse about her concern. The resident indicated she was told the questioning had been because the facility needed to know if she had a bowel movement or needed help cleaning herself after she went to the bathroom. Resident #9 indicated "she didn't need to ask to see my butt. She could have asked if I needed help or if I had a bowel movement."</p>	F000166	<p>F166RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCESIt is the policy of this facility to ensure that all residents, families and guests have the ability to file a grievance at anytime resulting in management follow through.what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ¿ Resident #9 was immediately interviewed by staff. Grievance form was completed. One on one education with the nurse regarding the grievance policy. One on one education with both nurse's aides regarding approach with care. Reportable submitted to ISDH. 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 had the potential to have been affected by the alleged deficient practice.¿ All staff will be in-serviced on the facility grievance policy. Education will be provided by the Director of Nursing/Designee and completed by December 18, 2013. what measures will be put into place or what systemic changes will be</p>	12/18/2013			

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	<p>Resident #9's clinical record was reviewed on 11/15/13, 1:45 p.m.</p> <p>Resident #9's current diagnoses included, but were not limited to, dementia and osteoporosis.</p> <p>Resident #9 had a current, 10/16/13, care plan problem regarding a history of incontinence due to dementia.</p> <p>Resident #9 had a current, 10/16/13, care plan problem regarding a self care deficit related to dementia and limited mobility.</p> <p>Resident #9 had a current, 10/23/13, admission, Minimum Data Set (MDS) assessment which indicated the resident did not have cognitive impairment for decision making, understood others and was understood by others.</p> <p>Resident #9's record lacked any documentation of an event related to toileting.</p> <p>During an 11/13/13, 1:56 p.m., interview, the Administrator indicated the facility Administration was unaware of any concerns regarding Resident #9 and toileting concerns regarding a staff asking to see her</p>		<p>made to ensure that the deficient practice does not recur; Grievance forms will be readily available at the front desk, the nurse's station on the second and third floor and outside the social service office. Customer Care rounds conducted by management staff to assure resident's needs are met on a daily basis. If concerns are noted, a grievance form will be completed. All staff will be in-serviced on the facility grievance policy. Education will be provided by the Director of Nursing/Designee and completed by December 18, 2013. 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 CQI monitoring tool called Grievance CQI will be utilized every week x 4, Monthly x 3, and every other month x3 for at least 6 months.¿ Data will be collected by DNS/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.¿ Non-Compliance with facility procedure may result in disciplinary action up to and including termination. by what date the systemic changes will be completed. December 18, 2013</p>				

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	<p>bottom.</p> <p>During an 11/14/13, 2:35 p.m., interview, CNA#2 indicated Resident #9 had recently become upset with her when she saw the resident coming out of the bathroom with her walker and asked the resident if she had "peed or pooped." "The resident became upset because she thought I was being nosey." CNA #2 indicated she used the words peed or pooped because she had said BM in the past and the resident did not understand her.</p> <p>During an 11/14/13, 2:38 p.m., interview CNA #3 indicated Resident #9 had recently become upset when asked about incontinent care and evening care. CNA #3 felt as if the resident wanted to handle these tasks herself and perhaps felt the CNA was questioning her abilities.</p> <p>During an 11/15/13, 9:00 a.m., interview with both the Memory Care Facilitator and Social Services Director, both indicated RN #1 should have completed a concern/grievance form after Resident #9 stated the CNA had asked to see her butt. Because the resident had not felt it was abusive or sexual in nature and had felt it was</p>				

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	<p>disrespectful instead, a concern form could have been completed instead of it being treated as abuse. RN #1 had not completed the form because she felt the problem was addressed. The Memory Care Facilitator and Social Services Director both felt the concern form would allow for follow-up which would include the resident feeling assured the situation was resolved.</p> <p>During an 11/15/13, 1:30 p.m., interview, LPN #1 indicated Resident #9 had approached her a couple days prior and expressed concern because she felt a CNA had asked to look at her bottom to see if it was clean. LPN #1 indicated she talked to the resident and two CNAs and felt there had been a misunderstanding. She determined the CNAs had been asking the resident if she had had a bowel movement and trying to determine if she needed toileting assistance. She indicated the resident did not feel the event was sexual or abusive and had felt disrespected. LPN #1 indicated she never verified anyone asking to see Resident #9's bottom was just an offer regarding assistance. LPN #1 indicated she spoke to the CNAs regarding how to offer assistance and inquire regarding bowel movements.</p>						

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	<p>LPN #1 indicated she felt she had cleared up the issue. LPN #1 indicated she had not completed a concern/grievance form or reported Resident #9's concerns to any other department. She indicated in hindsight she should have completed the form to allow social services to follow-up on the matter.</p> <p>A current, 8/13 (no day), facility policy titled "Resident Concerns and Grievances", which was provided by the Administrator on 11/14/13 at 1:10 p.m., indicated the following:</p> <p>"Definition: a grievance is any written or verbal concern by the resident...relating to resident care or the quality of service provided. * If a concern/grievance of any kind is noted, the Concern/Grievance Form is used. The person receiving the concern completes Section I..."</p> <p>3.1-7(a)(2)</p>						

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to develop a plan of care for a resident who refused to receive and/or participate in range of motion services as identified in the plan of care for 1 of 3 residents reviewed for restorative services. (Resident #66)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #66 was reviewed on 11/14/13 at 2:30 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, hypertension,</p>	F000280	F280RIGHT TO PARTICIPATE PLANNING CARE-REVISED CPIt is the policy of this facility to ensure that all residents, families and medical power of attorney may participate in the resident's plan of care planning. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ¿ Resident # 66 has been care planned for refusal of range of motion services.¿ Restorative aides have received one on one training about approach in offering range of motion services including reapproaching if a refusal is given. how other	12/18/2013			

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	<p>schizophrenia, chronic airway obstruction and dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 10/27/13, indicated Resident #66 was cognitively intact. Resident #66 received the following Activities of Daily Living (ADL) assistance; transfer-limited assistance with one person assist, ambulation-supervision, dressing-limited assistance with one person assist and hygiene-extensive assistance with one person assist. Resident #66 resided on the locked memory center.</p> <p>The health care plan assessment, dated 11/06/13, indicated Resident #66 required range of motion services to bilateral upper and lower extremities. Interventions for the problem included, but were not limited to, "passive range of motion to bilateral upper and lower extremities 6-7 days per week daily, demonstrate exercise and rest breaks as needed." Resident #66 also had a health care plan for episodes of delusion/hallucination. Interventions for the problem included, but were not limited to, "redirect resident to activities, offer to call her mother or provide a smoke break."</p>		<p>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 have the potential to be affected by the alleged deficient practice.All restorative care plans will be audited to address resident's participation or refusal. All licensed staff and Interdisciplinary team will be in-serviced on care planning for refusals. Education will be provided by the Director of Nursing/Designee and completed by December 18, 2013. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Care Plans will be reviewed weekly to ensure residents who benefit from ROM to ensure residents participation or documented refusal.Reviews will be conducted by MDS coordinator/designee.All licensed staff and Interdisciplinary team will be in-serviced on care planning for refusals. Education will be provided by the Director of 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 CQI monitoring tool called Care Plan Updating CQI will be utilized every week x 4, Monthly x 3, and every other month x3 for at least 6 months.¿ Data will be collected by DNS/Designee and</p>	

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	<p>During review of the restorative flow sheet, Resident #66 did not receive range of motion services on September 1, 2, 6, 16, 21, 22, 30, October 1, 2, 6, 25, 29, 31, November 2, 3, 4, 5, 6, 7, 9 and 13th. Resident #66 refused services on September 17, 18, 26, October 3, 4, 5, 7, 14, 17, 18, 21, 22 and November 8.</p> <p>During an interview on 11/14/13 2:36 p.m., LPN #4 indicated Resident #66 often refused restorative therapy. No care plan was identified for the resident refusing restorative services.</p> <p>3.1-35(g)(2)</p>		<p>submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.¿ Non-Compliance with facility procedure may result in disciplinary action up to and including termination. by what date the systemic changes will be completed. December 18, 2013</p>		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to follow the care plan for accurate documentation of resident meal intake and replacement for 1 of 2 residents reviewed for nutritional careplans. (Resident #98)</p> <p>Findings include:</p> <p>The clinical record for Resident #98 was reviewed on 11/14/13 at 2:00 p.m.</p> <p>Diagnoses for Resident #98 included, but were not limited to, atrial fibrillation, hypertension, glaucoma, muscle weakness, history of knee joint replacement, and diabetes mellitus type 2.</p> <p>The Minimum Data Set (MDS) assessment, dated 11/13/13, indicated Resident # 98 had severe cognitive impairment.</p> <p>The health care plan assessment, dated 11/11/13, indicated that Resident #98 had the potential for</p>	F000282	<p>F282SERVICES BY QUALIFIED PERSONS/PER CARE PLANit is the policy of this facility to ensure that all residents are taken care of according to the resident's personal plan of care.what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #98's meal intake on 11-14-13 was corrected immediately.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 have the potential to be affected by the alleged deficient practice.All nursing staff will be in-serviced on the facility Food and Fluid Intake Record- EMR policy. Education will be provided by the Director of Nursing/Designee and completed by December 18, 2013. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; -Meal Service manager/professional nursing staff will audit meal intakes for accuracy daily X3 by monitoring actual meal intake to the documented intake.All nursing</p>	12/18/2013	

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	<p>alteration in nutritional status due to the requirement of a therapeutic diet related to cardiac diagnoses. Approaches included, but were not limited to, "monitor food and fluid intake, encourage Resident #98 to continue eating, and offer substitute if 50% or less of any meal is consumed."</p> <p>An observation on 11/14/13 at 1:30 p.m., found Resident #98 in his room where a lunch tray had been placed in front of him on the bedside table. Resident #98 had not consumed any part of the meal. At 2:00 p.m., Resident #98 was again observed in his room with the lunch tray on the bedside table where the meal remained untouched. At 2:07 p.m., a review of the food and fluid intake record indicated Resident #98 had consumed 76-100% of the meal.</p> <p>During an observation and interview on 11/14/13 at 2:15 p.m., CNA #5 was shown the untouched lunch tray and the documentation of Resident #98's meal intake of 76-100%. CNA #5 indicated " I had to chart for the shift change."</p> <p>Review of a current, facility policy titled "Delivery and Documentation of Meal Service and Between Meal</p>		<p>staff will be in-serviced on the facility Food and Fluid Intake Record- EMR policy. Education will be provided by the Director of Nursing/Designee and completed by December 18, 2013. 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; andA CQI monitoring tool called Food and Fluid Documentation CQI will be utilized every week x 4, Monthly x 3, and every other month x3 for at least 6 months.Data will be collected by DNS/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed.Non-Compliance with facility procedure may result in disciplinary action up to and including termination. by what date the systemic changes will be completed.December 18, 2013</p>				

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	<p>Nourishments" which was provided by the DoN on 11/15/13 at 1:40 p.m., indicated the following:</p> <p>"Purpose: to accurately document resident intake of food and fluids. Review and document food and fluid intake on the Food/Fluid Intake Record. Assist residents in eating as needed. Follow the procedure for Substitutes for Food Refusals if the resident eats 50% or less of the meal. If a resident consumes less than 75% of the meal a substitution must be offered."</p> <p>3.1-35(g)(2)</p>			

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F000318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on record review and interview, the facility failed to ensure residents with an identified decline in range of motion receiving restorative nursing services received those services as identified in their plan of care for 2 of 3 residents reviewed for restorative services. (Resident #55 and #66)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #55 was reviewed on 11/14/13 at 2:51 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, dementia, hypothyroidism, anxiety and hypertension.</p> <p>The annual Minimum Data Set (MDS) assessment, dated 9/1/13, indicated Resident #55 was unable to complete the Brief Interview Mental Status (BIMS). Resident #55 received the following Activities of Daily Living (ADL) assistance; transfer-extensive</p>	F000318	F318INCREASE/PREVENT DECREASE IN RANGE OF MOTIONIt is the policy of this facility to ensure that all appropriate residents receive range of motion services to increase range of motion and/or prevent further decrease in range of motion.what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; ¿ Resident # 55 and # 66 will received range of motion services as per plan of care. 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 have the potential to be affected by the alleged deficient practice.All nursing staff will be in-serviced on the facility Restorative Nursing Program policy. Education will be provided by the Director of Nursing/Designee and completed by December 18, 2013. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; MDS	12/18/2013			

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	<p>assistance with two person assist, ambulation-did not occur, hygiene and bathing-total assistance with two person assist and toilet use-always incontinent of urine and always incontinent of bowel. The MDS indicated Resident #55 received passive range of motion 5 times in the last 7 calendar days. No additional therapies were received. Resident #55 resided on the locked memory center.</p> <p>The health care plan assessment, dated 9/10/13, indicated Resident #55 required range of motion program to bilateral upper and lower extremities 6-7 times per week. Interventions for the problem included, but were not limited to, "passive range of motion to bilateral upper and lower extremities to maintain current level of function, verbal prompts to explain what task you are doing and rest breaks as needed." Resident #55 also had a health care plan for a fall risk due to impaired gait. Interventions for the problem included, but were not limited to, "2 staff for transfers with use of stand lift and call light in reach."</p> <p>During review of the restorative flow sheet, Resident #55 did not receive range of motion services on September 1, 2, 6, 16, 21, 22, 30,</p>		<p>Nurse/Designee will review the restorative documentation daily. DNS Nurse/ Designee will ensure residents are offered restorative nursing services per plan of care by conducting daily rounds. 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 CQI monitoring tool called Range of Motion CQI will be utilized every week x 4, Monthly x 3, and every other month x3 for at least 6 months. Data will be collected by DNS/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed. Non-Compliance with facility procedure may result in disciplinary action up to and including termination. by what date the systemic changes will be completed. December 18, 2013</p>				

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	<p>October 1, 2, 6, 25, 31, November 2, 3, 4, 5, 6, 7, 9 and 13th.</p> <p>2. The clinical record for Resident #66 was reviewed on 11/14/13 at 2:30 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, hypertension, schizophrenia, chronic airway obstruction and dementia.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 10/27/13, indicated Resident #66 was cognitively intact. Resident #66 received the following Activities of Daily Living (ADL) assistance; transfer-limited assistance with one person assist, ambulation-supervision, dressing-limited assistance with one person assist and hygiene-extensive assistance with one person assist. Resident #66 resided on the locked memory center.</p> <p>The health care plan assessment, dated 11/18/13, indicated Resident #66 required range of motion program to bilateral upper and lower extremities 6-7 times per week. Interventions for the problem included, but were not limited to, "passive range of motion to bilateral</p>			

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	<p>upper and lower extremities, demonstrate exercise and rest breaks as needed." Resident #66 also had a health care plan for a fall risk due to impaired gait at times. Interventions for the problem included, but were not limited to, "call light in reach and therapy screen quarterly and as needed."</p> <p>During review of the restorative flow sheet, Resident #66 did not receive range of motion services on September 1, 2, 6, 16, 21, 22, 30, October 1, 2, 6, 25, 29, 31, November 2, 3, 4, 5, 6, 7, 9 and 13th. Resident #66 refused services on September 17, 18, 26, October 3, 4, 5, 7, 14, 17, 18, 21, 22 and November 8.</p> <p>During an interview on 11/14/13 2:36 p.m., LPN #4 indicated Resident #66 often refused restorative therapy. No care plan or other interventions were identified for the resident refusing restorative services.</p> <p>During an interview on 11/14/13 at 3:30 p.m., the Minimum Data Set (MDS) Coordinator indicated the facility did have the Restorative Aide provided staffing on the indicated dates rather than provide restorative aid.</p>				

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	<p>During an interview on 11/18/13 at 9:38 a.m., the Assistant Director of Nursing indicated the restorative aide would occasionally get pulled to staff. She indicated no other CNA's provided active or passive range of motion.</p> <p>3.1-42(a)(2)</p>				

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to identify and implement a plan of action to ensure range of motion services were provided. This deficient practice impacted 2 of 3 residents reviewed for range of motion services (Resident #66 and #55).</p> <p>Findings include:</p> <p>During an 11/18/13, 10:05 a.m.,</p>	F000520	F520COMMITTEE-MEMBERS/MEET QUARTERLY/PLANSit is the policy of this facility to meet for a quality assessment and assurance committee monthly to identify issues & develop and implement appropriate plans of correction.what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident # 55 and # 66 will received range of motion services as per plan of care based on plan of correction. how	12/18/2013	

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	<p>interview, the Administrator was questioned regarding the provision for range of motion services and the review of these services by the QAA Committee (Quality Assessment and Assurance). The Administrator was specifically questioned regarding the impact of range of motion services for Residents #66 and #55. The Administrator indicated she would review the records and provide information as soon as possible.</p> <p>During an 11/17/13, 10:55 a.m. interview, the Administrator indicated the QAA committee had reviewed the "Fit" program which includes therapies and restorative range or motion. The QAA committee did not identify a problem with the failure to provide range of motion services because their focus had not been in that area. The Administrator indicated had the focus have been wider the concern regarding lack of range of motion could possibly have been identified. The Administrator indicated currently 37 residents were involved in the restorative program which could include range of motion services.</p> <p>3.1-52(b)(2)</p>		<p>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 have the potential of being affected by the alleged deficient practice. All nursing staff will be in-serviced on the facility Restorative Nursing Program policy. Education will be provided by the Director of Nursing/Designee and completed by December 18, 2013. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Facility will utilize a CQI tool called Range of Motion monthly in the CQI monthly process. All nursing staff will be in-serviced on the facility Restorative Nursing Program policy. Education will be provided by the Director of Nursing/Designee and completed by December 18, 2013. 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 CQI monitoring tool called Range of Motion CQI will be utilized every week x 4, Monthly x 3, and every other month x3 for at least 6 months. Data will be collected by DNS/Designee and submitted to the CQI Committee. If the threshold of 95% is not met, an action plan will be developed. Non-Compliance with</p>		

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			facility procedure may result in disciplinary action up to and including termination. by what date the systemic changes will be completed. December 18, 2013	