STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155481		07/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00176284. Complaint IN00176284 - Substantiated. Federal/State deficiencies related to the allegations(s) are cited at F223, F226, and F241. Survey dates: July 7, 8, 9, 10, 13, 14, and 15, 2015 Facility number: 000455 Provider number: 155481 AIM number: 100291010 Census bed type: SNF: 17 SNF/NF: 75 Residential: 32 Total: 124 Census payor type: Medicare: 22 Medicaid: 47 Other: 23 Total: 92	F 0000	**Arbor Trace requestspaper compliance for the following deficiencies. This plan of correction is to serve as ArborTrace's credible allegation of compliance. Submission of thisplan of correction does not constitute an admission by Arbor Trace or its managementcompany that the allegations contained in the survey report is a true andaccurate portrayal of the provision of nursing care and other services in thisfacility. Nor does this submissionconstitute an agreement or admission of the survey allegations.**	

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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.			
F 0223 SS=A Bldg. 00	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents remained free from abuse. This affected 2 of 3 residents reviewed for abuse in a sample of 3. (Resident #C and Resident #F.) Findings included: 1.) Interview with Resident #C on 7/9/15 at 3:10 p.m., indicated the staff treated her good and with dignity and respect. Review of the record of Resident #C on 7/10/15 at 11:15 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, muscular atrophy, Alzheimer's disease and chronic	F 0223	**F223 483.13 (b)(1)(i) FREE FROMABUSE/INVOLUNTARY SECLUSION I. Abuse allegationwas reported to the State Department of Health at time of incident. Associate was suspended and subsequentlyterminated from employment at Arbor Trace. II. Our policy is tokeep all our residents free from any type of abuse. In the event that an unforeseen abuseincident occurs we will follow the Indiana State Department of Healthguidelines in regards to reporting. III. The systemicchange includes training for all chargenurses and managers will be held at a minimum of twice a year to include abusetraining. This training includes notificationof**	08/05/2015

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	pain. The Quarterly Minimum Date Set (MDS) assessment for Resident # C dated, 5/28/15, indicated the following: the resident usually was understood and she usually understands others, the resident had memory problems and she had modified independence for cognitive skills for daily decision making. Resident # C had no behaviors, the resident walks in her room and the corridor independently. Interview with LPN #1 on 7/9/15 at 2:08 p.m., indicated on 7/6/15, Resident #C came to the nursing station with her clothes on had a strong smell of urine. LPN #1 indicated her and CNA #3 gave the resident a shower. LPN #1 indicated the resident had no problems with bathing. LPN #1 indicated the resident became upset because she did not want to get her pillow wet and she escalated from there to the call police. The resident went into the hallway in her nightgown and the staff supervised her and let her walk to calm down. The CNA blow dried her hair in hallway in a chair. We assisted her back to her room and the resident came out in hallway and took nightgown off in hallway and laid down on the floor. The staff attempted to calm the resident and get her to go to room without success.		**the administrator immediately and the designee only when the administratoris not accessible. The training also includesthe immediate suspension of any identified or suspected staff members withallegations of mistreatment and the steps to determine that a thoroughinvestigation is completed during the suspension of any identified staff. In addition, all staff will complete abusetraining to identify and report allegations of mistreatment at a minimum oftwice a year and this same training will be provided to all staff during newhire orientation. The Nurse Consultant in-serviced the department managersand support personnel on July 28, 2015 in regards to the facility's abusepolicy. Thefacility held an additional re-in-service on 8/4/2015 for the staff on theabuse policy. This was given by theAdministrator and the DON. IV. SocialServices/Designee will interview three residents per day (5 days per week) for90 days, then three residents two times per week for 90 days, then fiveresidents per month for an additional 180 days to total 12 months ofmonitoring. The interview questionnaireis completed with any areas of**	

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	The resident was standing in the doorway yelling at the staff to call the police cause her hair was wet, she had a brief on and nothing else. CNA #5 came from long term care unit and asked if we needed help. LPN #1 told no, they were just trying to calm her and was giving her space in hope the resident would calm down. LPN #1 indicated the resident was smacking staff at this time. CNA #5 went between LPN #1 and CNA #3 and walked past the resident and went behind her and put her arms under the resident's arms from behind and put her onto her bed the wrong way with her feet at head of bed and her head at the foot of the bed. CNA #5 had a hold of both of the resident's wrist. LPN #1 told CNA #5 to let go of the resident. The resident sat on side of the bed and said "my arm my arm" LPN #1 indicated she assessed the resident and did not find anything wrong. LPN #1 indicated she had CNA #5 make out a statement and told her not give any resident care. LPN #1 reported the incident to the RN #2. RN #2 called and reported the incident to someone and escorted CNA #5 out of the building. The incident report dated, 7/6/15 at 3:30 a.m., indicated two staff members were trying to prevent Resident #C from coming out into the hallway naked. CNA #5 approached them and asked if they		**concern being brought to the attention of theadministrator/DON for follow up. Results of audits will be reported to the QACommittee monthly to assist with additional recommendations if necessary. COMPLIANCEDATE: 8/52015**	

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	needed help and the other two staff told her "no" , but CNA #5 decided to walk between the two staff members and came behind Resident #C and placed her arms under the resident's armpits securing her hands against her chest and guided her back to the resident's bed. CNA #5 then held Resident #C's hands down to prevent her from striking anyone until the resident yelled "my arm, my arm". CNA #5 let go of the resident's arms and left the room. The immediate action was on 7/6/15 the Executive Director was notified immediately. The Medical Doctor (MD) and family were notified. A pain and skin assessment was initiated. Social Services will follow for 72 hours. Staff interviews were initiated. CNA #5 was asked to leave the wing and have no further interactions with residents. CNA #5 was then asked to leave the building once the Executive Director was notified of the incident. The incident follow up for Resident #C provided by the Executive Director on 7/13/15 at 4:00 p.m., indicated on 7/10/15 Social Services followed up with Resident #C and she showed no signs of mood distress and does not remember the incident. CNA #5 was terminated for poor customer service. Interview on 7/14/15 at 9:55 a.m., with			

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	CNA #3 indicated she worked third shift and on 7/6/15 and had given Resident #C a shower. Resident #C was fine during the shower, but then became upset because her hair was wet. CNA #3 indicated she attempted to dry it, but the resident was upset so she left her alone for a moment to calm down and then she blow dried the resident's hair. Resident #C became upset because she didn't want her night gown on she wanted regular clothes on so she started taking her clothes off in the hallway. Resident #C was yelling "help me help call the cops" at that time CNA #5 came from another unit and asked if we needed help and LPN #1 told her "no" we did not need help, but CNA #5 stated "don't worry I will handle this" and went between LPN #1 and myself and put her arms under the resident's arms from behind and crossed her arms around the residents chest and drug her backwards to her bed and put her in her bed and then was holding her down on the bed with her hands above her head at foot board. The resident was yelling "my wrist my wrist". CNA #5 let go of the resident and left the unit. I assisted the resident to get dressed and calmed the resident down. Resident #C said she was fine and then came back out of her room and was knocking chairs over and knocking things off the desk. Resident #C wanted us to call the police			

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	because some girl had hurt her. LPN #1 didn't know what the protocol was and said she would wait until next day to do something about it. CNA #3 indicated she reported the incident to RN #2 on the private unit and she called the Director Of Nursing (DON). Interview with the Executive Director on 7/9/15 at 3:00 p.m., indicated the Director Of Nursing (DON) notified him of the incident with Resident #C on 7/6/15 at 3:33 a.m. Interview with RN #2 on 7/10/15 at 4:12 p.m., indicated on 7/6/15 LPN #1 and CNA #3 reported to her about the incident with CNA #5 and Resident #C. RN #2 indicated she reported the incident to the "on call" nurse and that nurse called the DON and reported it. RN #2 indicated she sat with CNA #5 while she wrote out a statement, then walked her to the time clock and escorted her out of the building. 2. The Executive Director provided an Incident Report Form on 7/14/15 at 4:10 p.m. The form included, but was not limited to: "...Staff had attempted in asking [Resident #F] to go to the dining room for lunch. After the third attempt [Resident #F] yelled I'm not getting out of the d**m chair and I'm not eating			

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	lunch. RN # 6 allegedly raised her voice at [Resident #F] stating, "Don't yell at me my kids don't even do that." This was witnessed by another employee...Executive Director was notified. Incident was called into ISDH at approximately 12:30 p.m. on 5/9/15. MD and family notified...Social services will follow up with [Resident #F] for 72 hours and as needed thereafter." The follow-up report that was provided at the same time by the Executive Director, included the same Brief Description of Incident and "...The employment of RN #6 was terminated due to rude or discourteous behavior as well as non-compliance of company policy. RN #6 admitted to saying the following to Resident #F, "Don't yell at me my kids don't even do that." This was witnessed by another employee. RN #6 asked witness after incident if she thought she yelled at Resident #F. Social Services followed up with Resident #F and found no signs of mood distress. Resident #F resides on our memory unit." Resident #F's record was reviewed on 7/14/2015 at 3:51 p.m. The record indicated Resident #F had diagnoses that included, but were not limited to, senile dementia, congestive heart failure, osteoarthrosis, muscle weakness, debility, depression, anemia, high blood pressure,			

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	and chronic pain. A quarterly Minimum Data Set (MDS) assessment, dated 6/4/15, indicated Resident #F was severely impaired, rarely/never made decisions in cognitive skills for daily decision making, had exhibited no moods or behaviors, had wandering 1 to 3 days, and walked with limited assist of 1. A care plan initiated on 7/10/14, indicated: "Problem: Resident has physical behavioral symptoms toward others attempting to hit, kick, verbal aggression, yelling, cursing, screaming at staff. Goal: Resident will accept assistance mobility, eating, toileting, bathing, dressing, personal hygiene, etc.) without hitting, shoving, scratching, sexually abusing, staff. Approach: Assess whether the behavior endangers the resident and/or others...Provide consistency in approaching the resident...When resident becomes physically abusive, STOP and try task later. Do not force to do task." During an interview, on 7/15/2015 at 10:34 a.m., CNA #7 indicated they were trying to get Resident #F up for lunch and she didn't want to get up. She told RN #6 who went down to her room and told Resident #F she needed to get up.			

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	Resident #F said she didn't feel good, and RN #6 said "Don't yell at me, my kids don't even yell at me". CNA #7 said she raised her voice and gritted her teeth and said it in a mean voice. CNA #7 indicated she told LPN #8 who went to the Assistant Director of Nursing within 5 minutes. The abuse prevention policy provided by the Executive Director on 7/10/15 at 10:06 a.m., indicated the definition of abuse was "the willful infliction of injury; unreasonable confinement; intimidation; punishment with resulting physical harm, pain or mental anguish; or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being." "Verbal abuse is defined as any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability." This Federal tag relates to complaint IN00176284. 3.1-27(a)(1) 3.1-27(b)			

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F 0226 SS=A Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview the facility failed to implement their policies on abuse. (Resident #C and Resident #F). Findings include: 1.) The incident report dated, 7/6/15 at 3:30 a.m., indicated two staff members were trying to prevent Resident #C from coming out into the hallway naked. CNA #5 approached them and asked if they needed help and the other two staff told her "no" , but CNA #5 decided to walk between the two staff members and came behind Resident #C and placed her arms under the resident's armpits securing her hands against her chest and guided her back to the resident's bed. CNA #5 then held Resident #C's hands down to prevent her from striking anyone until the resident yelled "my arm, my arm". CNA #5 let go of the resident's arms and left the room. The immediate action was on 7/6/15 the Executive Director was notified immediately. The Medical Doctor (MD) and family were notified. A pain and skin assessment was initiated.	F 0226	**F226 483.13 (c)** **DEVELOP/IMPLEMENTABUSE/ NEGLECT, ETC POLICIES** **I. Abuse allegationwas reported to the State Department of Health at time of incident. Associate was suspended and subsequentlyterminated from employment at Arbor Trace.** **II. Our policy is tokeep all our residents free from any type of abuse. In the event that an unforeseen abuseincident occurs we will follow the Indiana State Department of Healthguidelines in regards to reporting.** **III. The systemic changeincludes training for all charge nurses andmanagers will be held at a minimum of twice a year to include abusetraining. This training includesimmediate notification of the administrator and the designee only when theadministrator is not accessible. Thetraining also**	08/05/2015

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	Social Services will follow for 72 hours. Staff interviews were initiated. CNA #5 was asked to leave the wing and have no further interactions with residents. CNA #5 was then asked to leave the building once the Executive Director was notified of the incident. The incident follow up for Resident #C provided by the Executive Director on 7/13/15 at 4:00 p.m., indicated on 7/10/15 Social Services followed up with Resident #C and she showed no signs of mood distress and does not remember the incident. CNA #5 was terminated for poor customer service. Review of the record of Resident #C on 7/10/15 at 11:15 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, muscular atrophy, Alzheimer's disease and chronic pain. The Quarterly Minimum Date Set (MDS) assessment for Resident # C dated, 5/28/15, indicated the following: the resident usually was understood and she usually understands others, the resident had memory problems and she had modified independence for cognitive skills for daily decision making. Resident # C had no behaviors, the resident walks in her room and the corridor		**includes the immediate suspension of any identified or suspectedstaff members with allegations of mistreatment and the steps to determine thata thorough investigation is completed during the suspension of any identifiedstaff. In addition, all staff willcomplete abuse training to identify and report allegations of mistreatment at aminimum of twice a year and this same training will be provided to all staffduring new hire orientation.** **The Nurse Consultant in-serviced the department managersand support personnel on July 28, 2015 in regards to the facility's abusepolicy. Thefacility held an additional re-in-service on 8/4/2015 for the staff on theabuse policy. This was given by theAdministrator and the DON.** **IV.Social Services/Designee will interview three residents per day (5 days perweek) for 90 days, then three residents two times per week for 90 days, thenfive residents per month for an additional 180 days to total 12 months ofmonitoring. The interview questionnaireis completed with any areas of concern being brought to the**	

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	independently. Interview with LPN #1 on 7/9/15 at 2:08 p.m., indicated on 7/6/15, Resident #C was standing in the doorway yelling at the staff to call the police cause her hair was wet, she had a brief on and nothing else. CNA #5 came from long term care unit and asked if we needed help. LPN #1 told no, they were just trying to calm her and was giving her space in hope the resident would calm down. LPN #1 indicated the resident was smacking staff at this time. CNA #5 went between LPN #1 and CNA #3 and walked past the resident and went behind her and put her arms under the resident's arms from behind and put her onto her bed the wrong way with her feet at head of bed and her head at the foot of the bed. CNA #5 had a hold of both of the resident's wrist. LPN #1 told CNA #5 to let go of the resident. The resident sat on side of the bed and said "my arm my arm" LPN #1 indicated she assessed the resident and did not find anything wrong. LPN #1 indicated she had CNA #5 make out a statement and told her not give any resident care. LPN #1 reported the incident to the RN #2. RN #2 called and reported the incident to someone and escorted CNA #5 out of the building. Interview with the Executive Director on		**attention of theadministrator/DON for follow up. Results of audits will be reported to the QA Committee monthly to assistwith additional recommendations if necessary.** **COMPLIANCEDATE: 8/5/2015**	

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	7/9/15 at 3:00 p.m., indicated the Director Of Nursing (DON) notified him of the incident with Resident #C on 7/6/15 at 3:33 a.m. Interview with RN #2 on 7/10/15 at 4:12 p.m., indicated on 7/6/15 LPN #1 and CNA #3 reported to her about the incident with CNA #5 and Resident #C. RN #2 indicated she reported the incident to the "on call" nurse and that nurse called the DON and reported it. RN #2 indicated she sat with CNA #5 while she wrote out a statement, then walked her to the time clock and escorted her out of the building.			
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on record review and interview the facility failed to provide a resident dignity by not giving incontinence care timely which resulted in the resident having dried bowel movement on her hands. This affected 1 of 3 residents reviewed for dignity in 27 sampled. Findings include:	F 0241	**F241 483.15(a)** **DIGNITY AND RESPECTOF INDIVIDUALITY** **I. Resident #B nolonger resides in the facility.** **II. All residents whohave bowel incontinence have the potential to be affected. Patient observationswere completed**	08/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155481	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/15/2015

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	Resident #B's record was reviewed on 7/09/2015 at 11:26 a.m. The record indicated Resident #B had diagnoses that included, but were not limited to, Alzheimer's disease, urinary tract infection, anxiety, high blood pressure, chronic pain, constipation, and urinary retention. A Significant Change MDS, dated 5/27/15, indicated Resident #B was severely impaired, never/rarely made decisions in cognitive skills for daily decision making, required extensive assistance of 2 for bed mobility, toileting, and transfers, did not walk, was occasionally incontinent of bladder, and always continent of bowel. A hospice urinary assessment, dated 5/27/15, indicated Resident #B was incontinent, had impaired mobility, dependent for transfer, mobility/manual dexterity impairments, "Spoke with dtr (daughter) and hospice nurse/aide. Resident maintains control of bladder most of the time and despite occasional accidents, prefers to maintain her control." A care plan, with a start date of 4/21/15, indicated: "Resident is continent of bladder with risk for decline due to: recent UTI and needs assistance with		**with no other areas identified. All residents with bowel incontinence will receive peri-care per proper policyand procedure including assisting residents with hand washing.** **III. The systemicchange is upon hire CNAs will complete a competency check demonstratingperi-care skill including checking hands for being soiled. The competency checkfor peri-care skill will be completed annually for current staff. The facility re-in-serviced C.N.A.'s regardingperi-care and assisting residents with hand washing beginning on 8/4/2015. The facility also held an in-service thatsame day for the nursing personnel on peri-care and assisting residents with handwashing. This was presented by the DON.** **IV. The DON/Designeewill observe/complete skills validation by staff on five patients/residents perweek for 180 days, then five residents per month for an additional 180 days to total12 months of monitoring.** **This review willinclude residents that require assistance with toileting to ensure properperi-care and hand washing is completed.**	

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	mobility and toileting r/t (related to) weakness...Encourage resident to voice pain with urination and staff to observe resident for signs of UTI...Encourage resident/staff/family to report changes incontinence patterns or increased need for assistance. Notify physician of any changes. Staff to assist resident with toileting upon resident request and as needed. Utilize briefs/pads to manage incontinence episodes to promote skin integrity and dignity if needed." A care plan, with a start date of 4/22/15, indicated: "Irregular bowel movements R/T poor nutrition...Bowel assessment and monitor q3d (every 3 days)." A care plan, with a start date of 4/12/15, indicated: "Resident is at risk for constipation due to anti cholinergic side effects of medications and decreased mobility...Resident will have a regular, soft-formed bowel movement 2-3 times per week. Administer medications/enemas/suppository, as ordered and as needed...Follow facility bowel management protocol...Provide peri-care after defecation...Teach resident the importance of responding to, rather than delaying, urge to defecate." A "Resident Grievance/Complaint Log" was provided by the Social Service		**Any issue identified during the observationwill be immediately reviewed with the staff member and corrected. Results of audits will be reported to the QACommittee monthly to assist with additional recommendations if necessary.** **COMPLIANCE DATE: 8/5/2015**	

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	Director on 7/13/15 at 10:42 a.m., and indicated Resident #B's family member had voiced the following grievance: "On Saturday when family came to visit around 11:00, they found [Resident #B] in bed, there was no diaper on her, and the bed pad was soaked. They said that poop was everywhere and it stank really bad in the room. They said that they went to the nursing station, there was a CNA at the desk and a nurse. They asked the nurse why was looking like that, the CNA got up and went into the room to clean her up. After she was cleaned up, the staff had left the soiled linens all over the floor and walked out. They took [Resident #B] outside for an hour or so and when they came back in, the soiled linens were still on the floor...Wednesday morning, the family came in around 8:30 AM and found the hospice nurse cleaning off BM from [Resident #B's] hands again...." During a confidential interview, a staff member indicated there was not enough staff on the weekends to give good timely care, sometimes they schedule only two aides when they are suppose to have three. When there are only two aides, both have so many residents a piece that the resident are not given incontinent care timely and they will sometimes find residents that they feel like have sat in			

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	urine for a long time. They also cannot assist residents to the toilet when they need to. Residents end up sitting in front of the [nurse's] desk for long periods of time and they don't want to sit out here all day, they have pain and the aides don't have time to assist them to lay down. During the week it is ok cause they have three aides and a nurse. A confidential interview with a family member indicated the hospice nurse called her on a Tuesday in June to tell her what time she going in [to facility] and found her mother with dried BM (bowel movement) on her hands. She said 3 different times they had to wipe dried BM off the mattress. The day she went in and found her with dried BM and a wet bed, the CNA took off the soiled laundry and threw it on the floor; it was still there when they came back in from sitting outside with her mother. On the Monday after she found her mother soiled on Saturday, she spoke to the Director of Nursing, but after it happened on Wednesday she didn't talk to anyone about it. During an interview, on 7/14/2015 at 1:18 p.m., CNA #9 indicated the day they found Resident #B with BM on her hands, she did not have the half of the hall where Resident #B was at, and the			

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	CNA who had Resident #B was on a smoke break. The family member came up and asked what happened with her mother, she was covered from head to toe in BM and CNA #9 said she she didn't know, she didn't have that half of the hall. CNA #9 went to clean her up and then the other came back so they cleaned her up and it was old BM, dried. The other CNA said she had just been in there before her smoke break, then the daughter came in after that. After they cleaned Resident #B, they put her in her wheelchair, and the other CNA said "I'll get this" and CNA #9 was under the impression she would take out the linens and the linens were left there. She said she couldn't be sure, but she thought the linens were on the floor and didn't think they were in a bag. This Federal tag relates to complaint IN00176284. 3.1-3(t)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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	Based on record review and interview, the facility failed to transfer a resident with assistance of 2 persons as care planned, resulting in the resident being lowered to the floor, for 1 of 3 residents reviewed for accidents. (Resident #D) Finding include: Resident #D's record was reviewed on 7/9/15 at 11:08 a.m. Diagnoses included but were not limited to Alzheimer's disease, senile dementia, muscle weakness and atrophy, and osteoarthrosis. Resident #D's quarterly Minimum Data Set (MDS) assessment dated 5/23/15, indicated he was usually understood and he usually had the ability to understand others. He was moderately impaired for his cognitive skills for daily decision making. He required extensive assistance of 2 plus persons for bed mobility and transfer. He did not walk. He had impairment of both lower extremities and utilized a wheelchair for mobility. A Care Plan for Resident #D indicated the following: "Problem Start Date: 01/02/2015. At Risk for falls, related to impaired safety awareness, general weakness, need for extensive assistance with transfers and bed mobility, and	F 0282	**F282 483.20(k)(30(ii)SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **I. Resident #D careplan and C.N.A. assignment sheet was reviewed for accuracy during the survey.** **II. All residents atrisk for falls have the potential to be affected. Residents with falls andresidents with fall interventions have been reviewed to ensure that theirinterventions were in place and functional per their plan of care for fallprevention. The C.N.A. sheets werereviewed for accuracy. Any issues identified were corrected.** **III. The systemicchange includes that C.N.A.s and nurses will be educated upon hire and annuallythat interventions per the plan of care for fall prevention must be in placeand followed for residents. The facility re-in-serviced nursing personnel regardingfalls and following the care plan and C.N.A. sheets on 8/4/2015. This was presented by the DON.** **IV. The Director of Nursing or designee willobserve staff assisted transfers for residents who are at risk for falls**	08/05/2015

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	impulsivity. Approach Start Date: 01/16/2015. 2 assist for transfers. Approach Start Date: 06/19/2015. Two staff members for transfer." A Progress Note for Resident #D dated 6/8/15 at 11:16 p.m., indicated Resident #D had been transferred from his wheelchair to his bed by a CNA and his knees had buckled and he had been lowered to the floor. An Accident Investigation Form for Resident #D dated 6/18/15, indicated the following: On 6/18/15 at 6:30 p.m., a CNA had tried to transfer Resident #D from his chair to his bed. He had refused to stand and had to gradually be slid down to the floor. An Incident Report Worksheet for Resident #D dated 6/18/15, indicated the root cause of Resident #D being lowered to the floor was related to his knees buckling and weakness. The new prevention intervention for Resident #D would be 2 person assistance for all transfers. An interview with Unit Manager #4 on 7/13/15, at 12:59 p.m., indicated when Resident #D was lowered to the floor by a CNA on 6/18/15, he should have been transferred with assistance of 2 persons.		**todetermine the care plan is being followed. Any issue identified during theobservation will be immediately reviewed with the staff member and corrected. This audit will be completed 5 patients/residents per week for 180 days,then five residents per month for an additional 180 days to total 12 months ofmonitoring. Results of these audits will be reviewed at the monthly facilityQuality Assurance Committee meeting and frequency and duration of reviews willbe adjusted as needed.** **COMPLIANCE DATE: 8/5/2015**	

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	An interview with the Assistant Director of Nursing on 7/13/15 at 2:10 p.m., indicated when Resident #D was lowered to the floor by a CNA on 6/18/15, he was a 2 person assist for transfers on his Care Plan. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review the facility failed to accurately assess, monitor and prevent bruising for 2 of 3 residents who met the criteria for skin conditions (non pressure related) (Resident #64 and Resident #110). Findings include: 1.) During observation on 7/7/15 at 2:10 p.m., Resident #64 had multiple bruising on top of both her hands and two bruises on her right forearm. Resident #64	F 0309	**F309 483.25** **PROVIDECARE/SERVICES FOR HIGHEST WELL BEING** **I. Resident # 64 hasa current skin assessment identifying all bruising. Her side rails were paddedduring the survey. Resident # 110 has acurrent skin assessment identifying all bruising. His side rails were paddedduring the survey.** **II. All residents atrisk for bruising have the potential to be affected. An in house skin sweepwill be conducted by the**	08/05/2015

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	indicated she bruised easy. Observation and interview with Resident #64 on 7/9/15 at 10:05 a.m., indicated she bruised easy and felt like the bruising on her hands and arm were from the siderails on her bed. The resident had multiple bruising on her right and left hand that were in various stages of healing. The bruising ranged from black purple and blue in color. The resident also had a bruise on her right forearm that she indicated had been there a long time. The resident had plastic 1/2 siderails on her bed in the up position. There was no padding on the siderails. Review of the record of Resident #64 on 7/9/15 at 11:45 a.m., indicated the resident's diagnoses included, but were not limited to, skin disorder, abnormal gait, depression, hypotension, anxiety, hypertension, iron deficiency anemia, chronic pain and bipolar disorder. The Quarterly Minimum Data Set (MDS) assessment for Resident #64, dated 5/7/15, indicated the following: the resident understood and understands, and was cognitively intact for daily decision making, she could transfer herself with the supervision of one person, she could walk in her room with supervision set up only, the resident used a mobility device		**DON and Nursing administrative staff on 7/28/15 toidentify any areas of skin concern including bruising. The current skin assessments will be reviewedfor accuracy. Any issues identified will be corrected.** **III. The systemicchange includes that nurses and CNAs will be educated upon hire and annuallythat any skin concerns are reported upon identification to the nurse. Educationwill also include documentation of weekly skin assessments. The facilityre-in-serviced nursing personnel on skin concern identification and weekly skinassessments 8/4/2015. This was presentedby the DON.** **IV. The Director ofnursing or designee will complete a random audit of resident's skin assessmentsfor accuracy. This audit will be completedfor 5 residents per week for 180 days, then five residents per month for anadditional 180 days to total 12 months of monitoring. Results of these auditswill be reviewed at the monthly facility Quality Assurance Committee meetingand frequency and duration of reviews will be adjusted as needed.**	

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	of a walker and wheelchair. The physician order for Resident #64, dated 6/17/15, indicated the resident was ordered weekly head to toe skin inspection to be completed per licensed nurse. If any new areas are noted complete the change in condition event once a day on Tuesdays. The progress note for Resident #64, dated 6/23/15 at 12:00 p.m., indicated the resident had a 5 centimeter (cm) by 5 cm bruise on her left hand and a 2 cm by 2 cm bruise on her right forearm. The resident thinks she bumps it (hand and forearm) in her sleep. The progress note dated 7/4/15 at 9:41 p.m., indicated the resident had two small bruises on her left hand middle digit measuring 0.5 cm by 0.2 cm and the second bruise measured 0.5 cm by 0.5 cm. The resident stated her bruising appeared overnight. The progress note for Resident #64, dated 7/10/15 at 2:07 p.m., indicated the resident had bruises on both hands and right arm. The resident states she bruises easy and she had probably hit her hands and arms on something. The weekly skin assessments for		**COMPLIANCE DATE: 8/5/2015**	

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	Resident #64, dated 6/23/15, 6/30/15, 7/7/15, indicated no documentation of the resident's bruising. The weekly skin assessments all indicated "no new findings" and no current skin concerns related to bruising. Resident #64's care plan for bruising, dated 7/6/15, "indicated pad siderails, wheelchair etc as indicated, measure and record description of bruise location size, color signs of healing, analyze resident's bruise will dissipate without complications". Interview with Resident #64 on 7/10/15 at 1:10 p.m., indicated the facility had not padded the siderails and the siderails were in the up position when she was in the bed. The resident indicated it would be good to pad the siderails to help with her bruising. Observation of the rails were not padded and were in the up position the resident had plastic 1/2 siderails on both sides of her bed. Interview with the Director Of Nursing (DON) on 7/10/15 at 1:30 p.m., indicated the nurses should be measuring the bruises on Resident #64 weekly. Observation on 7/10/15 at 1:40 p.m. Unit Manager #4 measured Resident #64's bruising. The measurements on the left			

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	hand were bruise #1 was 4 centimeters (cm) by 2 cm, bruise #2 bruise was on the left hand ring finger measured 1.4 cm by 1 cm, the right hand knuckle of third finger was 1 cm by 0.6 cm, the right interior forearm was 2.8 cm by 1 cm and right posterior forearm was 2 cm by 2 cm, the right hand faint bruising on interior hand was 3.4 by 2 cm. Unit Manager #4 indicated she was unsure why the resident's siderails were not padded. Unit Manager #4 indicated the resident may have had her siderails padded in her old room, but had only been this hallway for about three weeks. Resident #64's record indicated she was moved from room 316 to room 108 on 6/3/15. 2.) Observation, on 7/8/15 at 11:42 a.m., of Resident #110 indicated dark purple bruising on left hand, left wrist area, left forearm and right hand. Review of Resident #110's record on 7/10/15 at 1:00 p.m., indicated his diagnoses included but were not limited to congestive heart failure, hypertension, rheumatoid arthritis, transient cerebral ischemia and diabetes mellitus, type II. Resident #110's Minimum Data Set (MDS) assessment dated 5/20/15,			

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	indicated he was understood and had the ability to understand others. He was cognitively intact for his daily decision making skills. Physician's recapitulation orders dated for July, 2015 indicated aspirin 40 mg once a day at 8:30 a.m., Coumadin 6 mg once a day at 5:00 p.m. Measure each non- pressure area: bruises, skin tears, incisions, ect. and complete skin observation for each area once a day on Friday 2:30 p.m. - 10:30 p.m. On 7/10/15 at 1:30 p.m., interview with Resident #110 indicated he turns himself over in bed and uses his arms on the bedrails to turn himself. He indicated "I'm always bruising myself." Review on 7/10/15 at 1:40 p.m., indicated weekly skin check per Licensed Nurse for June and July 2015, no documentation of bruising on right or left hands, right wrist or left forearm. Review of care plan for coumadin indicated started 6/16/15 - Problem: Resident is receiving anticoagulant therapy and is at risk for bleeding and/bruising. Goal: Resident will have no active bleeding. Approach: Administer anticoagulants as			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TRACE HEALTH & LIVING COMMUNITY	3701 HODGIN RD RICHMOND, IN 47374

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	ordered. Coordinate lab work. Avoid unnecessary sticks. Discourage use of razor with blade. Use electric razor. Monitor labs as ordered. Monitor vital signs daily. Observe for signs of active bleeding (nosebleeds, bleeding gum, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, hemoptysis, elevated temp, pain in joints, abdominal pain, epistaxis). Protect resident from injury/trauma. Care plan for bruising started 5/14/15 Problem: Resident receives anticoagulant medication. Is at risk for bruising. Goal: Resident will not experience bruising. Administer medications as ordered. Encourage resident to use caution going thru doorways, with ambulation - with or without walker, to avoid bumping into objects, furniture, doors, ect. Monitor lab work. Notify MD of results. Notify physician of bruising, if occurs. Observe for signs of active bleeding (nosebleeds, bleeding gum, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, hemoptysis, elevated temp, pain in joints, abdominal pain, epistaxis). Protect resident from injury/trauma.			

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	Interview with Director of Nursing(DON) on 7/14/15 at 1:40 p.m., indicated the nurse just discovered the bruising on Resident #110 she has completed the skin assessment sheets and we have up dated his care plan. Review of weekly skin condition assessment tool and care plan for bruising provided by DON on 7/14/15 at 2:00 p.m., indicated bruise to right hand measured 1.5 cm x 1 cm, bruise to right wrist measured 1.5 cm x 6 cm, bruise to left hand measured 1 cm x 1 cm, bruise to left forearm measured 1.2 cm x 1.5 cm, bruise to left forearm measured 2 cm x 1.5 cm. Care plan for bruising to right and left hands, right wrist and left forearm, updated on 7/14/15 indicated analyze resident's bruises to determine pattern/trend. Give resident verbal reminders not to ambulate/transfer without assistance. Keep call light in reach at all times. Manage pain with repositioning, treatment and medications, as ordered. Measure and record description of bruise (e.g., location, size (length and width), color, surrounding skin, presence/absence of signs of healing). Monitor and record any complaints of pain: location, duration, quality, alleviating factors, aggravating factors.			

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	Monitor and record any non-verbal signs of pain: (e.g., guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, ect.). Pad siderails. Treat area per order. Use mechanical devices with care (e.g., lifts, wheelchairs bedside tables, restraints, ect.). Review of wound management document provided by the DON on 7/13/15 at 3:25 p.m., indicated ... "The wound team: Meets each week/every seven (7) days, preferably the same day and time to benefit the resident (s) being assessed. Each wound will be visualized by the wound team to provide oversight of the care plan interventions and ensure that each resident's condition is accurately assessed in a timely manner... Any other skin condition that has the potential to worsen without adequate oversight..." 3.1-37(a)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey.	R 0000	**Arbor Trace requestspaper compliance for the following deficiencies. This plan of**	

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	Residential Census: 32 Sample: 7 Arbor Trace Health & Living Community was found to be compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.		**correction is to serve as ArborTrace's credible allegation of compliance. Submission of thisplan of correction does not constitute an admission by Arbor Trace or its managementcompany that the allegations contained in the survey report is a true andaccurate portrayal of the provision of nursing care and other services in thisfacility. Nor does this submissionconstitute an agreement or admission of the survey allegations.**	