

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155522	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036
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F 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: May 11-15, 18, 2015</p> <p>Facility number: 000372 Provider number: 155522 AIM number: 100289060</p> <p>Census bed type: SNF/NF: 65 Residential: 10 Total: 75</p> <p>Census payor type: Medicare: 5 Medicaid: 55 Other: 15 Total: 75</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000		
F 157 SS=D Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's</p>			

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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	<p>physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to promptly notify the resident's family and the resident's physician when the resident received another resident's medication in error for 1 of 4 residents reviewed for physician and family notification. (Resident #54)</p> <p>Findings include:</p>	F 157	<p>F157 NOTIFY OF CHANGES</p> <p>The incident occurred over 6 months ago and the physician and family were notified eventually but not promptly on the day of the incident so a corrective action for the day of the incident is not feasible at this moment in time. BUT the corrective action for future occurrences will be</p>	06/17/2015

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	<p>An 11/22/14, "Medication Error Report" indicated Resident #54 was given the wrong residents medication due to the employee went into the wrong room. Resident #54 was given 3 blood pressure medications that she did not normally receive and a narcotic for pain (Oxymorphine that she would not normally take. Resident #54 was sent to the Emergency Room (ER) due to a decreased blood pressure.</p> <p>Resident #54's clinical record was reviewed on 5/13/15 at 9:00 a.m. Resident #54's current diagnoses included, but were not limited to, Alzheimer's disease, thyroid disease, depression and hypertension.</p> <p>Resident #54 had an 11/22/14, 8:30 a.m., Nursing Note which indicated the QMA (qualified medication aide) inadvertently gave the resident another resident's medication. The resident was given 3 blood pressure/hypertensive medications which she did not normally receive and a narcotic pain medication. The Nursing Note, which was written by LPN#8, indicated "I told QMA to hold her normal HTN [hypertensive] medications and give other medications as ordered." Nursing personal would monitor the resident. Vital signs were: B/P 114/71</p>		<p>to follow the facility protocol for MD/Family Notification using the policy "Notifications-Resident Status". All medication administering staff will be re-educated on this policy by the DON/ADON by June 17, 2015. All new hire staff that administers medications will receive job specific orientation including the protocol for notifying MD/Family on medication errors or status changes during their initial orientation. The DON or designee receives a medication error report for each incident and will review the report for verification that the MD & Family were notified promptly of any medication error and/or status change. The DON or designee will address any non-compliance with following the protocol within 24 hours of receiving the med error report. The DON will track the notification verifications and discuss at each quarterly QA meeting.</p>	

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	<p>(blood pressure), HR- 63 (heart rate), R- 12 (respirations) and O2 sat - 91% (oxygen saturation).</p> <p>Resident #54 had an 11/22/14, 10:00 a.m., Nursing Note which indicated the resident was asleep and her vital signs were B/P- 103/63, HR-63, R - 14, O2 sat 96%.</p> <p>Resident #54 had an 11/22/14, 11:30 a.m., Nursing Note which indicated the residents vital signs were B/P- 99/62, HR-66, R-18, O2 sat 93%.</p> <p>Resident #54 had an 11/22/14, 1:42 p.m., Nursing Note which indicated, at approximately 12:55 p.m.(approximately 4 and 1/2 hours after the incorrect medication was given), the nurse checked on the resident and her vital signs were B/P-87/56, HR-58, R-9, O2 sat at 89% on room air. The DON, family and doctor were contacted and the resident was sent to the ER. This is the first time the clinical record indicated the physician and family had been notified.</p> <p>Resident #54 had an 11/22/14, 1:15 p.m., Physician's Order to send the resident to the Emergency room to evaluate and treat.</p> <p>During a 5/13/15, 1:33 p.m. interview</p>			

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	<p>with LPN #8 and the DON, both indicated the QMA accidentally gave Resident #54 the wrong medication. She then contacted LPN #8. LPN #8 contacted the DON. The DON made the choice to hold all hypertensive medications and administer the rest of Resident #54's morning medications. Both indicated the physician had not been involved in the discussion to administer the routine morning medications. Both indicated the nurse did not speak to the physician until approximately 12:55 p.m. Both indicated the record had no documentation of the family or physician being contacted or an attempted contact prior to 12:55 p.m. Both indicated at 12:55 p.m., when notified, the physician sent the resident to the emergency room.</p> <p>A current, undated, facility policy titled "Medication Error Policy/Procedure", which was provided by the Administrator on 5/15/15 at 1:10 p.m., indicated the following:</p> <p>"The medication error will be reported to the attending physician or physician on call for the attending physician as well as the party responsible for the resident."</p> <p>A current, undated, facility policy titled "Notifications-Resident Status", which was provided by the Administrator on</p>			

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F 224 SS=D Bldg. 00	<p>5/15/15 at 1:10 p.m., indicated the following:</p> <p>" It is the policy of CPVCC [Community Parkview Care Center] to promptly notify physician (sic) , resident, resident sponsor of changes in resident status. ...g. Situations deemed as necessary or appropriate to report that are in the best interest of the resident."</p> <p>3.5-1(a)(2)</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</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 observation, interview and record review, the facility failed to prevent neglect regarding incontinent care for 1 of 2 residents reviewed for incontinent care to prevent the development of or promote the healing of a pressure area. This deficient practice resulted in Resident #33's healed pressure area re-opening to a stage 2 pressure area on 5/15/15. (Resident #33)</p> <p>Findings include:</p>	F 224	<p>F224 PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION</p> <p>The resident affected by the deficient practice received immediate care upon awareness of the incident. The resident's assignment sheet was reviewed and updated to reflect hourly checks. An all nursing staff memo was distributed by the Administrator within the first hour of the incident</p>	06/17/2015	

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	<p>On 5/15/15 at 9:54 a.m., Resident #33 was observed lying in bed. She was lying on her right side, curled up, and her face in the mattress. Resident #33 was moaning and crying. The resident's gown was wet from her hips to the middle of her back with a dark ring around the wet area on her gown. Resident #33 had two saturated incontinent pads under her. The white sheet under the two incontinent pads had an oval shaped, wet, yellow area with a dried, dark outer ring.</p> <p>During an interview with CNA #3 on 5/15/15 at 10:07 a.m., she indicated the wet area on the white sheet was approximately 20 inches long by 12 inches wide, yellow stained, wet with dry edges. CNA #3 indicated the two incontinent pads under Resident #33 were wet, along with the resident's gown. She indicated the resident's gown was wet up to her mid back with a dried ring around the wet area.</p> <p>During an interview with CNA #9 on 5/15/15 at 10:15 a.m., she indicated the last time she had checked on Resident #33 was at 6:30 a.m., 30 minutes after the start of her shift. She indicated she was not aware the resident was on a turn schedule or on hourly checks. CNA #9 indicated there were three CNA's</p>		<p>to re-educate the nursing staff of the expectation to provide the necessary care to this and other residents. All nursing staff will read and acknowledge understanding with a signature page of the memo before each staff person's next scheduled shift. Upon awareness of the incident, another C.N.A was assigned to do care checks on all other dependent/incontinent residents to ensure no other resident was in this same situation. There were no other residents noted to be in a neglectful condition. The administrator began an investigation into this incident and reported the incident as an unusual occurrence. The C.N.A responsible for resident #33 was suspended pending the results of the investigation and was then terminated after the investigation showed she did not provide the necessary care to this resident as outlined in the resident's care plan and assignment sheet. The DON is implementing an "Hourly Rounding Program" that will encompass standard checks on all residents with documented visits. Staff is being educated daily at the morning huddles by the DON/ADON. A formal training on Hourly Rounding will be led by the DON & ADON with all nursing staff and other designated department staff to attend by June 17, 2015. The DON or designee will track the compliance with the Hourly Rounding Program, address</p>		

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	<p>currently working on the hall. CNA # 9 indicated she was assigned to provide care for Resident #33 on 5/15/15.</p> <p>During an observation of incontinence care for Resident #33 on 5/15/15 at 10:07 a.m., a reddened area was observed on the coccyx/left buttock. The area was sheared with loose white skin attached.</p> <p>The Wound Nurse was observed measuring the area to the coccyx/left buttock on 5/15/15 at 10:25 a.m. She indicated the wound was located on the coccyx and was a Stage 2 pressure area. The Wound Nurse indicated the measurements were 4.9 centimeters length by 4.0 centimeters width by 0.1 centimeters depth with a reddened and sheared area. The surrounding area was 4.1 centimeters length by 3.6 centimeters width. It had a red center with yellow slough around the open part of the wound.</p> <p>A review of the "Wound Nurse Assessment", dated 5/15/15, with an onset date of 5/15/15, indicated "...Reddened area measures 4.9 x 4.0 x 0.1 surrounding open area 4.1 x 3.6 Area stage 2 with red center and yellow slough around open part of wound. Skin very fragile and pink...."</p>		<p>non-compliance issues within 24 hours of incident, and review findings weekly with the Administrator and then quarterly during the QA meeting.</p>				

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	<p>During an interview with the Wound Nurse on 5/15/15 at 3:20 p.m., she indicated Resident #33's wound to her coccyx had been a healed stage 2 and now had reopened to the proximal area of the healed wound. She indicated the wound looked worse on 5/15/15 then it had on 5/12/15. She indicated the wound looked to be closed, pink with fragile skin around the healed prior stage 2 wound of the coccyx on 5/12/15. The Wound Nurse indicated the wound looked to have fresh shearing on 5/15/15.</p> <p>During an interview with the Hospice Nurse on 5/18/15 at 1:45 p.m., she indicated when she saw the resident the middle of last week, the area to the resident's coccyx was not open but approximately 1 centimeter length by 1 centimeter width with no depth. It looked like a rug burn, no loose skin, it was reddened.</p> <p>During an interview with the Administrator on 5/15/15 at 12:51 p.m., she indicated she had sent CNA #9 home pending an investigation for neglect of Resident #33.</p> <p>During an interview with the Administrator on 5/18/15 at 2:20 p.m., she indicated CNA #9 would not be returning to the facility because she had</p>			

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	<p>neglected to provide adequate care and services to Resident #33.</p> <p>Resident #33's clinical record was reviewed on 5/13/15 at 12:57 p.m. Resident #33's current diagnoses included, but were not limited to, dementia without behavioral disturbance, anxiety state, anemia, hypertension, closed fracture interchanteric section femur and depressive disorder.</p> <p>Resident #33 had a current, 4/6/15, significant change, Minimum Data Set assessment (MDS) which indicated: the resident was severely cognitively impaired and rarely or never made independent decisions. Resident #33 was totally dependent on staff assistance for mobility both on and off the unit, total dependence on staff for toilet use, hygiene and extensive assist with bed mobility.</p> <p>Resident #33 had a current 4/6/15, care plan problem/need regarding "impaired thought processes related to dementia/Alzheimer's." Approaches to this problem included but were not limited to, "needs cues with all decision making and communicate with resident and her family regarding resident's capabilities and needs."</p>			

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	<p>Resident #33 had a current 4/6/15, care plan problem/need regarding "activities of daily living self care deficit related to confusion, pain and impaired mobility." Approaches to this problem included but were not limited to, "...Check resident hourly to ensure needs are met...and ...resident requires mechanical aid as needed for transfers per 2 staff."</p> <p>Resident #33 had a current 4/6/15, care plan problem/need regarding "skin breakdown r/t (related to) occasional B&B (bowel and bladder) incontinence..." Approaches to this problem included but were not limited to, "Cleanse skin and dry after each incontinent episode...."</p> <p>A current undated facility policy titled "Perineal Care Policy/Procedure " provided by the Administrator on 5/18/15 at 8:45 a.m. indicated the following:</p> <p>"1. Perineal care will be provided as needed...to residents between bathing to prevent irritation, infection and skin breakdown, and to promote resident comfort and dignity.</p> <p>2. Direct-care staff will be responsible for determining when a resident is in need of... perineal care, and will be responsible to provide perineal care to the</p>			

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	<p>resident..."</p> <p>A current undated facility policy titled "Pressure Ulcer Prevention and Treatment Policy/Procedure" provided by the Administrator on 5/18/15 at 8:45 a.m. indicated the following:</p> <p>"1. Prevention</p> <p>...c. Pressure ulcer risk factors and interventions are as follows:</p> <p style="padding-left: 40px;">i. Potential risk factors: moisture, friction and shearing, immobility, bowel and bladder incontinence, poor nutrition, decreased mental awareness, medications, co-morbid or terminal disease processes.</p> <p style="padding-left: 40px;">ii. Potential interventions relative to risk factors: protective barriers, routine skin checks, routine toileting, repositioning...</p> <p>3. Staging of Pressure Ulcers</p> <p>...Stage II: A partial thickness loss of skin layers that present clinically as</p>			

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F 248 SS=E Bldg. 00	<p>an abrasion, blister, or shallow crater...."</p> <p>A current undated facility policy titled "ABUSE POLICY" provided by the Administrator on 5/11/15 at 2:00 p.m. indicated the following:</p> <p>"...STATEMENT: Our facility is committed to protecting our residents from abuse by anyone. We will ensure that each resident is free from ...mental and physical neglect...</p> <p>...POLICY: Residents residing in this facility will be treated with dignity and respect in accordance with their individual needs. They will not be subjected to ...mental or physical neglect...</p> <p>DEFINITIONS:</p> <p>NEGLECT - Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness - this includes both passive and active neglect...."</p> <p>3.1-27(a)(3)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p>			

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	<p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review, the facility failed to develop an activity program which included out-of-room activities for cognitively impaired dependent residents. This deficient practice impacted 5 of 5 residents reviewed for activity programing. (Residents #12, #54, #33, #4 and #69)</p> <p>Findings include:</p> <ol style="list-style-type: none"> Resident #12 was observed in his room either in bed or in his wheelchair during the following dates and times. Although the television was on at times, the resident did not open his eyes, turn toward the TV, laugh when appropriate or complete any action which would indicate he was watching TV: 5/11/15, 1:46 p.m.-the resident was in bed asleep 5/12/15, 8:09 a.m.- the resident in his wheelchair with his eyes closed. He did not respond to his name. 5/12/15, 10:25 a.m.- the resident was in bed asleep 5/13/15, 3:53 p.m. - the resident was in his wheelchair with his eyes closed. 	F 248	<p>F248 ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT</p> <p>The Activity Calendar/Program has been revised to include at least one out of the room daily activity for cognitively impaired dependent residents. The Activity Program will continue to conduct 1:1 visits and attempt to have residents participate in current activity calendar in addition to the specific out of room activity events. The Administrator and Activity Director met to discuss possible activities of interest including sensory groups, porch visits, bird watching, movies, doll therapy, pet therapy, poetry reading, hand massages, musical entertainment, church sessions, and pre-meal socialization to name just a few. The Activity Director and DON/ADON will educate and promote the revised Activity Program to alert nursing staff of daily events and assistance with attendance at said events by cognitively impaired dependent residents. The monthly Activity Calendar will be reviewed by the Administrator. The resident attendance log will be reviewed</p>	06/17/2015

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	<p>5/14/15, 9:43 a.m. - the resident was in bed asleep</p> <p>5/14/15, 10:37 a.m. - the resident was in bed asleep.</p> <p>5/14/15, 2:22 p.m. - the resident was in bed asleep and facing wall.</p> <p>Resident #12's clinical record was reviewed on 5/15/2015 at 8:34 a.m.</p> <p>Resident #12's current diagnoses included, but were not limited to, Alzheimer's disease and depression.</p> <p>Resident #12 had a 3/10/15, quarterly, Minimum Data Set (MDS) assessment, which indicated the Resident did not speak, was severely cognitively impaired and rarely or never made decision and was totally dependent on staff assistants for mobility.</p> <p>Resident #12 had a current, 3/10/15, care plan problem/need regarding "Dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] Physical Limitations, Immobility, Cognitive deficits Severe cognitive impairments, poor response to audio, tactile, or visual stim [stimulation]...."</p> <p>Approaches to this problem included, but were not limited to, "Avoid activities that involve overly demanding cognitive tasks. Engage in simple, structured activities, Assist/escort to activities of</p>		<p>weekly by the Activity Director & Administrator with changes and/or other interventions attempted for poor attendance. The Activity Director will summarize and review the attendance logs at the quarterly QA meeting. The new calendar began June 1, 2015</p>	

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	<p>choice that reflect prior interests and desired activity level." The 8 approaches to Resident #12's activity care plan need had not been updated since 10/4/10.</p> <p>Review of Resident #12's Activity Attendance Records for April and May (1-14) 2015 indicated the following: April 2015- Resident #12 was asleep and not available for out-of-room activities 22 of 30 days May 2015 (1-14) - Resident #12 was asleep and not available for out-of-room activities 10 of 14 days.</p> <p>2. Resident #54 was observed in her room either in bed or in her broda chair during the following dates and times. Although the television was on at times, the resident did not turn toward the TV, laugh when appropriate or complete any action which would indicate she was watching TV:</p> <p>5/11/15, 2:09 p.m.- in bed asleep 5/11/15, 7:59 a.m. - in room in her broda chair 5/12/2015, 1:20 p.m. - the resident was in bed moving about, the tv was on 5/13/2015, 12:52 p.m. - the resident was in bed asleep with the tv on 5/13/2015, 2:13 p.m. - the resident was in bed asleep 5/14/2015, 9:16 a.m.- the resident was in</p>			

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	<p>bed asleep 5/14/2015, 9:42 a.m.- the resident was in bed asleep 5/14/2015, 10:41 a.m.- the resident was in bed asleep 5/14/2015, 2:21 p.m. -the resident was in bed moving restlessly.</p> <p>Resident #54's clinical record was reviewed on 5/13/15 at 9:00 a.m. Resident #54's current diagnoses included, but were not limited to, Alzheimer's disease, thyroid disease, depression and hypertension.</p> <p>Resident #54 had a current, 2/6/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident rarely or never understood others, had unclear speech, rarely or never made decisions and was totally dependent on staff for mobility.</p> <p>Resident #54 had a current, 2/6/15, care plan problem/need regarding "[name] dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] Physical limitation, Cognitive deficits." Approaches to this problem included, but were not limited to, "Assure that the activities [name] attending (sic) are: Compatible with physical and mental capabilities; Compatible with known interest and</p>			

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	<p>preferences; Adapted as needed... Compatible with individual needs and abilities; and age appropriate."</p> <p>Review of Resident #54's attendance record for March, April, May (1-14) 2015 indicated the following:</p> <p>March 2015 - the resident was asleep and unavailable for activities 11 of 31 days. April 2015 - the resident was asleep and unavailable for activities 20 of 30 days. May 2015 - the resident was asleep and unavailable for activities 5 of 14 days.</p> <p>3. Resident #33 was observed in her room during the following dates and times.</p> <p>On 5/12/15 at 9:20 a.m., Resident #33 was lying in bed with her eyes open.</p> <p>On 5/12/15 at 1:19 p.m., Resident #33 was lying in bed with her eyes closed.</p> <p>On 5/13/15 at 2:33 p.m., Resident #33 was seated in her broda chair in her room. She appeared to be resting. Resident #33 opened her eyes when spoken to, but did not speak. An activity of karaoke was currently being provided in the main dining room.</p> <p>On 5/13/15 at 3:30 p.m., Resident #33 was lying in bed with her eyes closed.</p>			

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	<p>On 5/14/15 at 8:59 a.m., Resident #33 was lying in bed with her eyes closed.</p> <p>On 5/14/15 at 9:25 a.m., Resident #33 was lying in bed. She was lying on her right side facing the wall with her eyes closed.</p> <p>On 5/14/15 at 2:14 p.m., Resident #33 was lying in bed with her eyes closed. An activity of "Move and Groove" was scheduled for 2pm.</p> <p>On 5/14/15 at 3:00 p.m., Resident #33 was lying in bed with her eyes closed. She was lying on her right side facing the wall.</p> <p>On 5/15/15 at 9:54 a.m., Resident #33 was lying in bed on her right side facing the wall. She was moaning and crying.</p> <p>Resident #33's clinical record was reviewed on 5/13/15 at 12:57 p.m. Resident #33's current diagnoses included, but were not limited to, dementia without behavioral disturbance, anxiety state and depressive disorder.</p> <p>Resident #33 had a current, 4/6/15, significant change, Minimum Data Set assessment (MDS). It indicated the resident was severely cognitively</p>			

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	<p>impaired and rarely or never made independent decisions. Resident #33 was totally dependent on staff assistance for mobility both on and off the unit.</p> <p>A review of Resident #33's activity calendars for March, April and May 2015 provided by the Activity Director on 5/14/15 at 3:50 p.m., indicated the following:</p> <p>The March, 2015 activity calendar indicated 26 of 31 days Resident #33 was asleep or unavailable for activities.</p> <p>The April, 2015 activity calendar indicated 27 of 30 days Resident #33 was asleep or unavailable for activities.</p> <p>The May, 2015 activity calendar indicated 11 of 13 days reviewed Resident #33 was asleep or unavailable for activities.</p> <p>Resident #33 had a current 4/6/15, care plan problem/need regarding "impaired thought processes related to dementia/Alzheimer's." Approaches to this problem included but were not limited to, "needs cues with all decision making and communicate with resident and her family regarding resident's capabilities and needs."</p>			

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	<p>Resident #33 had a current 4/6/15, care plan problem/need regarding "activities of daily living self care deficit related to confusion, pain and impaired mobility." Approaches to this problem included but were not limited to, "encourage the resident to participate to the fullest extent possible with each interaction and resident requires mechanical aid as needed for transfers per 2 staff."</p> <p>Resident #33 had a current 4/6/15, care plan problem/need regarding "dependent on staff for activities, cognitive stimulation, social interaction hard of hearing, poor vision, and dementia. Needs assist and encouragement to activities, attends church activities and receives 1:1's twice a week, naps after meals." Approaches to this problem included but were not limited to: "resident needs assist and encouragement to attend activity functions and prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as church, entertainments 1:1 visits."</p> <p>4. On 5/14/15 at 8:38 a.m., Resident #4 was seated in her wheelchair in front of the TV in the resident lounge. The TV program was the "Today Show". The</p>			

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	<p>resident's eyes alternated between being closed and looking around the room.</p> <p>On 5/14/15 at 10:22 a.m., Resident #4 was in the main dining room, seated in her wheelchair, during a sing-along activity. She was awake. She was not participating in the activity.</p> <p>On 5/14/15 at 2:37 p.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 05/15/15 at 8:40 a.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 5/15/15 at 10:28 a.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 5/15/15 at 11:16 a.m., Resident #4 was observed in her room sitting in her wheelchair. Her TV was on the same programming as her roommate's TV. The sound on Resident #4's TV was turned off. She was awake.</p> <p>On 5/15/15 at 2:06 p.m., Resident #4 was seated in her wheelchair in her room. She was facing her TV, which was turned off. She was awake.</p> <p>On 5/18/15 at 9:14 a.m., Resident #4 was seated in her wheelchair in her room. She was facing her TV, which was on the same programming as her roommate's TV. The sound on Resident #4's TV was turned off. She was awake.</p> <p>On 05/18/15 at 10:33 a.m., Resident #4</p>			

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	<p>was seated in her wheelchair at "Move and Groove". She was asleep.</p> <p>During an interview on 5/14/15 at 8:49 a.m., CNA #1 indicated that Resident #4 attended Bingo and "Move and Groove" at the facility. She indicated that the resident was not able to actively participate in the activities.</p> <p>Resident #4's clinical record was reviewed on 5/13/15 at 1:07 p.m. Resident #4's diagnosis included, but was not limited to, profound intellectual impairment. PASRR review dated 9/1/14 indicated she met requirements for services.</p> <p>Resident #4 had a current, 3/7/15, annual Minimum Data Set (MDS) which indicated: the resident was moderately cognitively impaired ,and rarely or never made independent decisions, was totally dependent on staff for transfers, and was totally dependent on staff for mobility.</p> <p>Resident #4 had a current care plan, revised and reviewed on 3/7/15, for encouragement and assistance to attend activities. Interventions included, but were not limited to, the following: "...Assure that the activities the resident is attending are: Compatible with the residents [sic] physical and mental</p>			

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	<p>capabilities ...Compatible with the residents [sic] individual needs and abilities; and Age appropriate...Engage in simple, structured activities.... "</p> <p>Review of Resident #4's activity attendance record indicated that Resident #4 was sleeping and did not attend any activities on 16 of 31 days in March 2015, 10 of 30 days in April 2015, and 1 of 13 days reviewed in May 2015.</p> <p>5. Resident #69 was observed on the following dates and times:</p> <p>On 5/12/2015 at 8:33 a.m., Resident #69 was sitting in her wheel chair in her room with her head down. The TV was on but the resident was not watching it.</p> <p>On 5/12/2015 at 12:51 p.m., Resident #69 was sitting in her room in the recliner with her head down and eyes closed.</p> <p>On 5/13/2015 at 9:27 a.m., Resident #69 was sitting in her recliner in her room with her head down and eyes closed</p> <p>On 5/13/2015 at 12:48 p.m., Resident #69 was sitting at the dining room table on the 300 hall drinking coffee.</p> <p>On 5/14/2015 at 9:55 a.m., Resident #69 was sitting in her recliner with feet hanging over the side of the foot rest.</p>			

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	<p>The TV was on but the resident was not watching it. The resident indicated she needed to use the toilet. Staff assisted with her care.</p> <p>On 5/14/2015 at 12:15 p.m., Resident #69 was sitting at the dining room table on the 300 hall eating lunch.</p> <p>On 5/15/2015 at 8:15 a.m., Resident #69 was sitting at the dining room table on the 300 hall eating breakfast.</p> <p>On 5/15/2015 at 8:43 a.m., Resident #69 was sitting in the recliner in her room with her head bowed and eyes closed.</p> <p>Resident #69's clinical record was reviewed on 5/15/15 9:30 a.m. The resident's current diagnoses included but were not limited to, congestive heart failure, atrial fibrillation, hypertension, depression, dementia, cerebral vascular accident.</p> <p>Resident #69 had a current, 2/20/15, Minimum Data Set assessment which indicated the resident had severe cognitive impairment and needed assistance for decision making.</p> <p>The care plan, dated 11/25/14, indicated Resident #69 had impaired cognitive function related to short term memory</p>			

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	<p>loss. The goal was for the resident to maintain her current level of cognitive function by the resident being engaged in "simple, structured activities that avoid overly demanding tasks, and keep resident to a consistent routine and assist with all decision making."</p> <p>Review of the March, 2015 activity attendance record indicated Resident #69 did not have any out-of-room activities for 30 out of 31 days aside from dining.</p> <p>Review of the April, 2015 activity attendance record indicated Resident #69 did not have any out-of-room activities for 30 out of 30 days aside from dining.</p> <p>Review of the May, 2015 activity attendance record indicated Resident #69 did not have any out-of-room activities for 12 out of 13 days reviewed aside from dining.</p> <p>6. During the week of May 11 through 15, 2015, this was National Nursing Home Week, the activity schedule was as follows: "Monday 5/11 10:00 a.m., Move & Groove 2:00 p.m., Crafts Tuesday 5/12 10:00 a.m., Move & Groove 2:00 p.m., Resident Council</p>			

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	<p>Wednesday 5/13 10:00 a.m., Move & Groove 2:00 p.m., Games 5:00 p.m., Restaurant Evening</p> <p>Thursday 5/14 10:00 a.m., Grace Baptist 2:00 p.m., Move & Groove 7:00 p.m., Bingo</p> <p>Friday 5/15 10:00 a.m., Popcorn 2:00 p.m., Manicures."</p> <p>During the month of March, 2015, 27 of 31 days had only 2 activities scheduled and 4 of 31 days had only 3 activities scheduled.</p> <p>During the month of April, 2015, 24 of 30 days had only 2 activities scheduled and 5 of 30 days had only 3 activities scheduled.</p> <p>During the month of May, 2015, (days 1-15), 11 of 13 days had only 2 activities scheduled and 2 of 13 days had only 3 activities scheduled.</p> <p>During an interview on 5/15/15 at 8:51 a.m., CNA #2 indicated there were no residents on bed rest at the facility.</p> <p>During an interview on 5/15/15 at 8:58 a.m., CNA #3 indicated there were no residents on bed rest at the facility.</p>			

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	<p>During a 5/14/15, 2:30 p.m., interview, the Activity Director indicated Residents #12, #54, #33, #4 and #69 were all five cognitively impaired and dependent on staff assistance for activity participation and attendance. He indicated each day of the week had 2 to 3 group activities scheduled. He indicated none of the group activities scheduled for the facility were designed to meet the needs of cognitively impaired residents. He had not assessed the cognitively impaired residents individually to identify each resident's needs. He had decided cognitively impaired residents did not need any out of room activities and had simply designated all of them to have 2 in-room activities a week. When Minimum Data Set assessments were completed and residents were not available for activities due to sleep, he had not made any changes to the resident's care plan to ensure out-of-room activities.</p> <p>Review of the 5/12/15, facility completed, "Resident Census And Conditions Of Residents" indicated 53 of the facility's 65 residents had some form of dementia.</p>			

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F 280 SS=E Bldg. 00	<p>Review of an undated facility list titled "BIMS 7 and below" indicated 28 of the facility's 65 residents were severely cognitively impaired and rarely or never made decisions.</p> <p>3.1-33(a)</p> <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 observation, interview and record review, the facility failed to review and revise care plans for cognitively impaired dependent residents who had low activity attendance for 5 of 5 residents reviewed for activity</p>	F 280	<p>F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLAN</p> <p>All activity care plans for current residents will be reviewed and updated accordingly by June 17,</p>	06/17/2015

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	<p>programing. (Residents #12, #54, #33, #4 and #69)</p> <p>Findings include:</p> <p>1. Resident #12 was observed in his room either in bed or in his wheelchair during the following dates and times. Although the television was on at times, the resident did not open his eyes, turn toward the TV, laugh when appropriate or complete any action which would indicate he was watching TV: 5/11/15, 1:46 p.m.-the resident was in bed asleep 5/12/15, 8:09 a.m.- the resident in his wheelchair with his eyes closed. He did not respond to his name. 5/12/15, 10:25 a.m.- the resident was in bed asleep 5/13/15, 3:53 p.m. - the resident was in his wheelchair with his eyes closed. 5/14/15, 9:43 a.m. - the resident was in bed asleep 5/14/15, 10:37 a.m. - the resident was in bed asleep. 5/14/15, 2:22 p.m. - the resident was in bed asleep and facing wall.</p> <p>Resident #12's clinical record was reviewed on 5/15/2015 at 8:34 a.m. Resident #12's current diagnoses included, but were not limited to, Alzheimer's disease and depression.</p>		<p>2015 by the Activity Director. The Care Plan will be reviewed at a minimum of once a quarter and revisions will be date stamped accordingly. The Care Plan Coordinator will review the care plans for all disciplines once a quarter and note any area that has not been updated for that quarter. The Care Plan Coordinator will communicate to the respective department for compliance with the review & update notation. The Activity Director will summarize the findings of each quarter's care plan review during the quarterly QA meeting.</p>		

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	<p>Resident #12 had a 3/10/15, quarterly, Minimum Data Set (MDS) assessment, which indicated the resident did not speak, was severely cognitively impaired and rarely or never made decision and was totally dependent on staff assistants for mobility.</p> <p>Resident #12 had a current, 3/10/15, care plan problem/need regarding "Dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] Physical Limitations, Immobility, Cognitive deficits Severe cognitive impairments, poor response to audio, tactile, or visual stim [stimulation]...." Approaches to this problem included, but were not limited to, "Avoid activities that involve overly demanding cognitive tasks. Engage in simple, structured activities, Assist/escort to activities of choice that reflect prior interests and desired activity level." The 8 approaches to Resident #12's activity care plan need had not been updated since 10/4/10.</p> <p>Review of Resident #12's Activity Attendance Records for April and May (1-14) 2015 indicated the following: April, 2015- Resident #12 was asleep and not available for out-of-room activities 22 of 30 days May, 2015 (1-14) - Resident #12 was</p>			

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	<p>asleep and not available for out-of-room activities 10 of 14 days.</p> <p>2. Resident #54 was observed in her room either in bed or in her broda chair during the following dates and times. Although the television was on at times, the resident did not turn toward the TV, laugh when appropriate or complete any action which would indicate she was watching TV:</p> <p>5/11/15, 2:09 p.m.- in bed asleep 5/11/15, 7:59 a.m. - in room in her broda chair 5/12/2015, 1:20 p.m. - the resident was in bed moving about, the tv was on 5/13/2015, 12:52 p.m. - the resident was in bed asleep with the TV on 5/13/2015, 2:13 p.m. - the resident was in bed asleep 5/14/2015, 9:16 a.m.- the resident was in bed asleep 5/14/2015, 9:42 a.m.- the resident was in bed asleep 5/14/2015, 10:41 a.m.- the resident was in bed asleep 5/14/2015, 2:21 p.m. -the resident was in bed moving restlessly.</p> <p>Resident #54's clinical record was reviewed on 5/13/15 at 9:00 a.m. Resident #54's current diagnoses included, but were not limited to,</p>			

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	<p>Alzheimer's disease, thyroid disease, depression and hypertension.</p> <p>Resident #54 had a current, 2/6/15, quarterly, Minimum Data Set (MDS) assessment which indicated the resident rarely or never understood others, had unclear speech, rarely or never made decisions and was totally dependent on staff for mobility.</p> <p>Resident #54 had a current, 2/6/15, care plan problem/need regarding "[name] dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] Physical limitation, Cognitive deficits." Approaches to this problem included, but were not limited to, "Assure that the activities [name] attending (sic) are: Compatible with physical and mental capabilities; Compatible with known interest and preferences; Adapted as needed...Compatible with individual needs and abilities; and age appropriate."</p> <p>Review of Resident #54's attendance record for March, April, May (1-14) 2015 indicated the following:</p> <p>March, 2015 - the resident was asleep and unavailable for activities 11 of 31 days.</p> <p>April, 2015 - the resident was asleep and</p>			

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	<p>unavailable for activities 20 of 30 days. May, 2015 - the resident was asleep and unavailable for activities 5 of 14 days.</p> <p>3. A review of Resident #33's activity calendars for March, April and May 2015 provided by the Activity Director on 5/14/15 at 3:50 p.m., indicated the following:</p> <p>The March, 2015 activity calendar indicated 26 of 31 days Resident #33 was asleep or unavailable for activities.</p> <p>The April, 2015 activity calendar indicated 27 of 30 days Resident #33 was asleep or unavailable for activities.</p> <p>The May, 2015 activity calendar indicated 11 of 13 days Resident #33 was asleep or unavailable for activities.</p> <p>Resident #33 was observed in her room during the following dates and times.</p> <p>On 5/12/15 at 9:20 a.m., Resident #33 was lying in bed with her eyes open.</p> <p>On 5/12/15 at 1:19 p.m., Resident #33 was lying in bed with her eyes closed.</p> <p>On 5/13/15 at 2:33 p.m., Resident #33 was seated in her broda chair in her room. She appeared to be resting. Resident #33 opened her eyes when</p>			

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	<p>spoke to but did not speak. An activity of karaoke was currently being provided in the main dining room.</p> <p>On 5/13/15 at 3:30 p.m., Resident #33 was lying in bed with her eyes closed.</p> <p>On 5/14/15 at 8:59 a.m., Resident #33 was lying in bed with her eyes closed.</p> <p>On 5/14/15 at 9:25 a.m., Resident #33 was lying in bed. She was lying on her right side facing the wall with her eyes closed.</p> <p>On 5/14/15 at 2:14 p.m., Resident #33 was lying in bed with her eyes closed. An activity of "Move and Groove" was scheduled for 2pm.</p> <p>On 5/14/15 at 3:00 p.m., Resident #33 was lying in bed with her eyes closed. She was lying on her right side facing the wall.</p> <p>On 5/15/15 at 9:54 a.m., Resident #33 was lying in bed on her right side facing the wall. She was moaning and crying.</p> <p>Resident #33's clinical record was reviewed on 5/13/15 at 12:57 p.m. Resident #33's current diagnoses included, but were not limited to, dementia without behavioral disturbance,</p>			

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	<p>anxiety state and depressive disorder.</p> <p>Resident #33 had a current 4/6/15, significant change, Minimum Data Set assessment (MDS) indicated the resident was severely cognitively impaired and rarely or never made independent decisions. Resident #33 was totally dependent on staff assistance for mobility both on and off the unit.</p> <p>Resident #33 had a current care plan problem/need regarding "dependent on staff for activities, cognitive stimulation, social interaction hard of hearing, poor vision, and dementia. Needs assist and encouragement to activitys [sic] and church activitys [sic] and receives 1:1s 2xs a week, Naps after meals...is now on hospice" with a revision date of 4/7/15. Approaches to this problem included but were not limited to "...resident needs assist and encouragement to attend activity functions..." with a date initiated on 7/5/2013 and "...prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as church, entertainments 1:1 visits..." with a date initiated on 7/5/2013. The approaches showed no revision since 7/5/2013.</p>			

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	<p>4. On 5/14/15 at 8:38 a.m., Resident #4 was seated in her wheelchair in front of the TV in the resident lounge. The TV program was the "Today Show". The resident's eyes alternated between being closed and looking around the room.</p> <p>On 5/14/15 at 10:22 a.m., Resident #4 was in the main dining room, seated in in her wheelchair, during a sing-along activity. She was awake. She was not participating in the activity.</p> <p>On 5/14/15 at 2:37 p.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 05/15/15 at 8:40 a.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 5/15/15 at 10:28 a.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 5/15/15 at 11:16 a.m., Resident #4 was observed in her room sitting in her wheelchair. Her TV was on the same programming as her roommate's TV. The sound on Resident #4's TV was turned off. She was awake.</p> <p>On 5/15/15 at 2:06 p.m., Resident #4 was seated in her wheelchair in her room. She was facing her TV, which was turned off. She was awake.</p> <p>On 5/18/15 at 9:14 a.m., Resident #4 was seated in her wheelchair in her room. She was facing her TV, which was on the same programming as her roommate's</p>			

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	<p>TV. The sound on Resident #4's TV was turned off. She was awake.</p> <p>On 05/18/15 at 10:33 a.m., Resident #4 was seated in her wheelchair at "Move and Groove". She was asleep.</p> <p>During an interview on 5/14/15 at 8:49 a.m., CNA #1 indicated that Resident #4 attended Bingo and "Move and Groove" at the facility. She indicated that the resident was not able to actively participate in the activities.</p> <p>During an interview on 5/15/15 at 8:51 a.m., CNA #2 indicated there were no residents on bed rest at the facility.</p> <p>During an interview on 5/15/15 at 8:58 AM CNA #3 indicated there were no residents on bed rest at the facility.</p> <p>Resident #4 's clinical record was reviewed on 5/13/15 at 1:07 p.m. Resident #4's diagnosis included, but was not limited to, profound intellectual impairment. PASRR review, dated 9/1/14, indicated she met requirements for services.</p> <p>Resident #4 had a current, 3/7/15, annual Minimum Data Set (MDS) which indicated: the resident was moderately cognitively impaired ,and rarely or never</p>			

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	<p>made independent decisions, was totally dependent on staff for transfers, and was totally dependent on staff for mobility.</p> <p>Review of document titled "Case Conference Agreement" from the Developmental Disabilities agency, dated 8/22/14, indicated Resident #4's identified needs as "social stimulation and cognitive stimulation."</p> <p>Resident #4 had a current care plan, revised and reviewed on 3/7/15, for encouragement and assistance to attend activities. Interventions included, but were not limited to, the following: "...Assure that the activities the resident is attending are: Compatible with the residents [sic] physical and mental capabilities ...Compatible with the residents [sic] individual needs and abilities; and Age appropriate...Engage in simple, structured activities.... "</p> <p>Review of Resident #4 ' s activity attendance record indicated that Resident #4 was sleeping and did not attend any activities on 16 of 31 days in March, 2015, 10 of 30 days in April, 2015, and 1 of 13 days reviewed in May, 2015.</p> <p>5. Resident #69 was observed on the following dates and times:</p> <p>On 5/12/2015 at 8:33 a.m., Resident #69</p>			

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	<p>was sitting in her wheel chair in her room with her head down. The TV was on but the resident was not watching it.</p> <p>On 5/12/2015 at 12:51 p.m., Resident #69 was sitting in her room in the recliner with her head down and eyes closed.</p> <p>On 5/13/2015 at 9:27 a.m., Resident #69 was sitting in her recliner in her room with her head down and eyes closed</p> <p>On 5/13/2015 at 12:48 p.m., Resident #69 was sitting at the dining room table on the 300 hall drinking coffee.</p> <p>On 5/14/2015 at 9:55 a.m., Resident #69 was sitting in her recliner with feet hanging over the side of the foot rest. The TV was on but the resident was not watching it. The resident indicated she needed to use the toilet. Staff assisted with her care.</p> <p>On 5/14/2015 at 12:15 p.m., Resident #69 was sitting at the dining room table on the 300 hall eating lunch.</p> <p>On 5/15/2015 at 8:15 a.m., Resident #69 was sitting at the dining room table on the 300 hall eating breakfast.</p> <p>On 5/15/2015 at 8:43 a.m., Resident #69 was sitting in the recliner in her room</p>			

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	<p>with her head bowed and eyes closed.</p> <p>Resident #69's clinical record was reviewed on 5/15/15 9:30 a.m.</p> <p>Resident's current diagnoses included but were not limited to, congestive heart failure, atrial fibrillation, hypertension, depression, dementia, cerebral vascular accident.</p> <p>Resident #69 had a current, 2/20/15, Minimum Data Set assessment which indicated the resident had severe cognitive impairment and needed assistance for decision making.</p> <p>Review of the March, 2015 activity attendance record indicated Resident #69 did not have any out-of-room activities for 30 out of 31 days aside from dining.</p> <p>Review of the April, 2015 activity attendance record indicated Resident #69 did not have any out-of-room activities for 30 out of 30 days aside from dining.</p> <p>Review of the May, 2015 activity attendance record indicated Resident #69 did not have any out-of-room activities for 12 out of 13 days aside from dining.</p> <p>The care plan, dated 11/25/14, indicated Resident #69 had impaired cognitive function related to short term memory</p>			

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F 309 SS=D Bldg. 00	<p>loss. The goal was for the resident to "maintain current level of cognitive function by resident being engaged in "simple, structured activities that avoid overly demanding tasks, and keep resident to a consistent routine and assist with all decision making." The care plan was not updated to identify individual out-of-room activity interests.</p> <p>During a 5/14/15, 2:30 p.m., interview, the Activity Director indicated Residents #12, #54, #33, #4 and #69 were all five cognitively impaired and dependent on staff assistance for activity participation and attendance. He had not assessed the cognitively impaired residents individually to identify each residents needs. When Minimum Data Set assessments were completed and resident were not available for activities due to sleep, he had not made any changes to the resident's care plan to ensure out-of-room activities.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest</p>			

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	<p>practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to implement and monitor a fluid restriction for 1 of 1 residents reviewed for dialysis services. (Resident # 40)</p> <p>Findings include:</p> <p>Resident #40's clinical record was reviewed on 5/14/15 at 8:34 a.m. Resident #40's current diagnoses included, but were not limited to, history of acute renal failure and renal insufficiency.</p> <p>Resident #40's clinical record indicated a physician's order for a 1500mL (milliliter) fluid restriction of fluid daily. Clinical record indicated nursing was to offer 100mL of fluids every shift and to document the percentage taken.</p> <p>During an interview on 5/14/15 at 8:43 a.m., Resident #40 indicated she did not monitor her fluid restriction. She indicated the facility monitored this for her.</p> <p>During an interview, on 5/14/15 at 8:46 a.m., CNA # 1 indicated Resident #40 received fluids as desired. She indicated</p>	F 309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>The communication process for alerting staff of a resident who is on fluid restriction now includes that information to be noted on the Team Sheet, The C.N.A. assignment sheet, the Dietary Meal Ticket and the Medication Administration Record (MAR). All staff will be educated on the location of this information by the DON/ADON by June 17, 2015. All new hire staff will be educated during general orientation/job specific orientation. The DON or designee will ensure that this information is kept current for each resident on a fluid restriction. The IDT will conduct a monthly audit for each affected resident to ensure that the communication process is in compliance (verify the information is on the Team Sheet, The C.N.A. assignment sheet, The Dietary Meal Ticket and the MAR). The audit findings will be documented on the audit log and reviewed quarterly during the QA meeting by the DON.</p>	06/17/2015

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F 314 SS=G Bldg. 00	<p>she was not aware of the resident's fluid restriction.</p> <p>During an interview, on 5/14/15 at 2:32 p.m., LPN # 6 indicated she was not aware of Resident #40's fluid restriction.</p> <p>During an interview, on 5/15/15 at 8:51 a.m., CNA #2 indicated she was not aware of Resident #40's fluid restriction.</p> <p>During an interview on 5/15/15 at 8:58 a.m., CNA # 3 indicated she was not aware of Resident #40's fluid restrictions.</p> <p>During an interview on 5/15/15 at 9:29 a.m., LPN #7 indicated Resident #40 was on a fluid restriction. She indicated that the amount of fluids specified for every shift should be documented by the nurse in the resident's Medication Administration Record (MAR). She indicated that this documentation was not present in the resident's MAR at the time of the interview.</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure</p>			

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	<p>sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview and record review, the facility failed to prevent the development of a pressure area due to lack of incontinent services resulting in the re-opening of a pressure area for 1 of 2 residents reviewed for pressure area prevention and treatment. This deficit practice resulted in Resident #33's healed pressure area re-opening to a stage 2 pressure area on 5/15/15. (Resident #33)</p> <p>Findings include:</p> <p>1. On 5/15/15 at 9:54 a.m., Resident #33 was observed lying in bed. She was lying on her right side, curled up, and her face in the mattress. Resident #33 was moaning and crying. The resident's gown was wet from her hips to the middle of her back with a dark ring around the wet area on her gown. Resident #33 had two saturated incontinent pads under her. The white sheet under the two incontinent pads had an oval shaped, wet, yellow area with a dried, dark outer ring.</p> <p>During an interview with CNA #3 on</p>	F 314	<p>F314 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES</p> <p>The resident affected by the deficient practice received immediate care upon awareness of the incident. The resident's wounds were measured by the Wound Care Nurse on May 15th after the incident occurred. The Wound Care Nurse received the initial report on Monday May 11th during morning huddle meeting that this resident had a reddened area possibly shearing but failed to complete a skin assessment on this skin area until Friday May 15th when the ISDH surveyor observed the resident's condition. There is no documented history of a previous pressure ulcer in this area. This wound was not documented as being a previously healed or closed wound. The area in question was noted on May 11th to be reddened and was not evaluated again until May 15th in which at that time it was a stage II. The lack of incontinence care and repositioning that occurred on the morning of May 15th could be contributing factors to the progression of the area to a stage II, but the resident</p>	06/17/2015

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	<p>5/15/15 at 10:07 a.m., she indicated the wet area on the white sheet was approximately 20 inches long by 12 inches wide, yellow stained, wet with dry edges. CNA #3 indicated the two incontinent pads under Resident #33 were wet, along with the resident's gown. She indicated the resident's gown was wet up to her mid back with a dried ring around the wet area.</p> <p>During an interview with CNA #9 on 5/15/15 at 10:15 a.m., she indicated the last time she had checked on Resident #33 was at 6:30 a.m., 30 minutes after the start of her shift. She indicated she was not aware the resident was on a turn schedule or on hourly checks. CNA #9 indicated there was three CNA's currently working on the hall. CNA # 9 indicated she was assigned to provide care for Resident #33 on 5/15/15.</p> <p>During an observation of incontinence care for Resident #33 on 5/15/15 at 10:07 a.m., a reddened area was observed on the coccyx/left buttock. The area was sheared with loose white skin attached.</p> <p>The Wound Nurse was observed measuring the area to the coccyx/left buttock on 5/15/15 at 10:25 a.m. She indicated the wound was located on the coccyx and was a Stage 2 pressure area.</p>		<p>has multiple other conditions that could also be contributing factors.</p> <p>To prevent future occurrences of not providing the necessary care, an all nursing staff memo was distributed by the Administrator within the first hour of the incident to re-educate the nursing staff of the expectation to provide the necessary care to this and other residents. All nursing staff will read and acknowledge understanding with a signature page of the memo before each staff person's next scheduled shift. The administrator began an investigation into this incident and reported the incident as an unusual occurrence. The C.N.A responsible for resident #33 was suspended pending the results of the investigation and was then terminated after the investigation showed she did not provide the necessary care to this resident as outlined in the resident's care plan and assignment sheet. The DON is implementing an "Hourly Rounding Program" that will encompass standard checks on all residents with documented visits. Staff is being educated daily at the morning huddles. A formal training on Hourly Rounding will be led by the DON & ADON with all nursing staff and other designated department staff to attend by June 17, 2015. The DON or designee will track the compliance with the Hourly Rounding Program, address non-compliance issues within 24</p>	

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	<p>The Wound Nurse indicated the measurements were 4.9 centimeters length by 4.0 centimeters width by 0.1 centimeters depth with a reddened and sheared area. The surrounding area was 4.1 centimeters length by 3.6 centimeters width. It had a red center with yellow slough around the open part of the wound.</p> <p>During an interview with the Wound Nurse on 5/15/15 at 3:20 p.m., she indicated Resident #33's wound to her coccyx had been a healed stage 2 and now had reopened to the proximal area of the healed wound. She indicated the wound looked worse on 5/15/15 than it had on 5/12/15. She indicated the wound looked to be closed, pink with fragile skin around the healed prior stage 2 wound of the coccyx on 5/12/15. The Wound Nurse indicated the wound looked to have fresh shearing on 5/15/15.</p> <p>During an interview with the Hospice Nurse on 5/18/15 at 1:45 p.m., she indicated when she saw the resident the middle of last week, the area to the resident's coccyx was not open but approximately 1 centimeter length by 1 centimeter width with no depth. It looked like a rug burn, no loose skin, it was reddened.</p>		hours of incident, and review findings weekly with the Administrator and then quarterly during the QA meeting.				

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	<p>A review of the "Wound Nurse Assessment", dated 5/15/15, with an onset date of 5/15/15, indicated "...Reddened area measures 4.9 x 4.0 x 0.1 surrounding open area 4.1 x 3.6 Area stage 2 with red center and yellow slough around open part of wound. Skin very fragile and pink...."</p> <p>Resident #33's clinical record was reviewed on 5/13/15 at 12:57 p.m. Resident #33's current diagnoses included, but were not limited to, dementia without behavioral disturbance, anxiety state, anemia, hypertension, closed fracture interochantheric section femur and depressive disorder.</p> <p>Resident #33 had a current, 4/6/15, significant change, Minimum Data Set assessment (MDS) which indicated: the resident was severely cognitively impaired and rarely or never made independent decisions. Resident #33 was totally dependent on staff assistance for mobility both on and off the unit, total dependence on staff for toilet use, hygiene and extensive assist with bed mobility.</p> <p>Resident #33 had a current 4/6/15, care plan problem/need regarding "impaired thought processes related to dementia/Alzheimer's." Approaches to</p>			

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	<p>this problem included but were not limited to, "needs cues with all decision making and communicate with resident and her family regarding resident's capabilities and needs."</p> <p>Resident #33 had a current 4/6/15, care plan problem/need regarding "activities of daily living self care deficit related to confusion, pain and impaired mobility." Approaches to this problem included but were not limited to, "...Check resident hourly to ensure needs are met...and ...resident requires mechanical aid as needed for transfers per 2 staff."</p> <p>Resident #33 had a current 4/6/15, care plan problem/need regarding "skin breakdown r/t (related to) occasional B&B (bowel and bladder) incontinence..." Approaches to this problem included but were not limited to, "Cleanse skin and dry after each incontinent episode...."</p> <p>A current undated facility policy titled "Perineal Care Policy/Procedure " provided by the Administrator on 5/18/15 at 8:45 a.m. indicated the following:</p> <p>"1. Perineal care will be provided as needed...to residents between bathing to prevent irritation, infection and skin breakdown, and to promote resident</p>			

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	<p>comfort and dignity.</p> <p>2. Direct-care staff will be responsible for determining when a resident is in need of... perineal care, and will be responsible to provide perineal care to the resident...." A current undated facility policy titled "Pressure Ulcer Prevention and Treatment Policy/Procedure" provided by the Administrator on 5/18/15 at 8:45 a.m. indicated the following:</p> <p>"1. Prevention</p> <p>...c. Pressure ulcer risk factors and interventions are as follows:</p> <p style="padding-left: 40px;">i. Potential risk factors: moisture, friction and shearing, immobility, bowel and bladder incontinence, poor nutrition, decreased mental awareness, medications, co-morbid or terminal disease processes.</p> <p style="padding-left: 40px;">ii. Potential interventions relative to risk factors: protective barriers, routine skin checks, routine toileting, repositioning...</p> <p>3. Staging of Pressure Ulcers</p>			

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F 333 SS=G Bldg. 00	<p>...Stage II: A partial thickness loss of skin layers that present clinically as an abrasion, blister, or shallow crater...."</p> <p>3.1-40(a)(2)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, interview and record review, the facility failed to ensure a resident was not given the wrong medication resulting in a drug overdose and hospitalization for 1 of 1 resident reviewed for a significant medication errors. (Resident #54)</p> <p>Findings include: During a 5/12/15, 3:18 p.m., interview, Resident #54's family member indicated Resident #54 had been given the wrong person's medication sometime in the winter months. She indicated, as a result of receiving the wrong medication, Resident #54 had been hospitalized for approximately three days for a drug overdose.</p>	F 333	<p>F333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The incident occurred over 6 months ago, a corrective action for the day of the incident is not feasible at this moment in time. BUT the corrective action for future occurrences will be to follow the facility protocol for administering medications which includes using the "5 Rights" to accurately identify the correct resident to the medications administered. The MAR books were updated to contain a picture of each resident with their MAR sheets to again identify the resident accurately. The QMA that committed the med error will be re-educated on this policy and complete a competency evaluation with the DON/ADON by June 17,</p>	06/17/2015

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	<p>An 11/22/14, "Medication Error Report" indicated Resident #54 was given the wrong resident's medication due to the employee went into the wrong room. Resident #54 was given 3 blood pressure medications that she did not normally receive and a narcotic for pain (Oxymorphone) that she would not normally take. Resident #54 was sent to the Emergency Room (ER) due to a decreased blood pressure.</p> <p>Resident #54's clinical record was reviewed on 5/13/15 at 9:00 a.m. Resident #54's current diagnoses included, but were not limited to, Alzheimer's disease, thyroid disease, depression and hypertension.</p> <p>Resident #54 had an 11/22/14, 8:30 a.m., Nursing Note which indicated the QMA (qualified medication aide) inadvertently gave the resident another resident's medication. The resident was given 3 blood pressure/hypertensive medications which she did not normally receive and a narcotic pain medication. The Nursing Note, which was written by LPN #8, indicated "I told QMA to hold her normal HTN [hypertensive] medications and give other medications as ordered." Nursing personal would monitor the resident. Vital signs were: B/P 114/71</p>		<p>2015. All medication administering staff will be re-educated on the Medication Administration Policy using the "5 Rights" to correctly identify the resident by June 17, 2015 by the DON/ADON. All new hire medication administering staff will receive job specific orientation including this policy. This policy will be reviewed at least annually by all medication administering staff. The DON/ADON or designee will conduct once a week random observations of med passes to ensure that the policy is being followed. Any non-compliance with the policy will be addressed at that moment with disciplinary action enforced. The findings of the observations will be reviewed by the DON/ADON during the quarterly QA meeting.</p> <p>The DON will complete a scope of practice review with the Administrator by June 17, 2015 to understand the boundaries of involving the physician for decisions regarding withholding or administering medications when a med error occurs.</p>	

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	<p>(blood pressure), HR- 63 (heart rate), R-12 (respirations) and O2 sat - 91% (oxygen saturation).</p> <p>Resident #54's routine vital signs for October through November 2015 were: B/P 131/67 to 155/84 Pulse/Heart Rate 61-79 Respiratory Rate 18-20 O2 sats 94-99% on room air.</p> <p>Resident #54 had an 11/22/14, 10:00 a.m., (1 and 1/2 hours after the error was first documented) Nursing Note which indicated the resident was asleep and her vital signs were B/P- 103/63, HR-63, R - 14, O2 sat 96%.</p> <p>Resident #54 had an 11/22/14, 11:30 a.m., (1 and 1/2 hours between documented vital signs) Nursing Note which indicated the resident's vital signs were B/P- 99/62, HR-66, R-18, O2 sat 93%.</p> <p>Resident #54 had an 11/22/14, 1:42 p.m., Nursing Note which indicated at approximately 12:55 p.m. the nurse checked on the resident and her vital signs were B/P-87/56, HR-58, R-9, O2 sat at 89% on room air. The DON, family and doctor were contacted and the resident was sent to the ER.</p>			

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	<p>Resident #54 had an 11/12/4, 1:15 p.m., Physician's Order to send her to the Emergency room to evaluate and treat.</p> <p>Resident #54 had an 11/22/14 hospital report which indicated: " resp rate [respiration rate] down to 9 at nursing home. Was given Narcan [anti-narcotic] in ER.... Renal Failure: note urine output down this am ... Lab results: CREAT 1.98* BUN 22 [no range given]...</p> <p>ASSESSMENT: 1. Accidental overdose, initial encounter 2. Narcotic-induced respiratory depression ... 5. CHF ...NYHA [New York Heart Association] class III, chronic systolic 6. Respiratory depression 7. Renal failure 8. other specified hypertension."</p> <p>Resident #54 had an 11/22/14, "Hospital Admission History and Physical" which indicated: "accidental overdose. Pt [patient] was in per [ambulance name] from parkview nursing home. Pt was given a different person's medication this morning at 0930 [9:30 a.m.]. Pt was given potassium 10 mEq, Zantac 150 mg [acid reducer], Amlodipine 10 mg [heart medication], Bystolic 10 mg [blood pressure medication], Colace 100 mg [stool softener], Duloxetine 60 mg</p>			

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	<p>[anti-depressant] , lutein tab [eye vitamin], lisinopril 40 mg [hypertensive], multi- vitamin, Namenda 7 mg [Alzheimer's medication], Omeprazole 40 mg [acid reducer], and Oxymorphone 30 mg [narcotic pain medication]. Pt's BP and RR [respiratory rate] low. Pt LOC [level of consciences] decreased."</p> <p>Resident #54 had the following laboratory results during her hospitalization:</p> <p>11/22/14 Admission labs: AST/SGOT (liver function)-147 H (range 14-36); ALT/SGPT (liver function)- 98 H (R 9-52), alkaline phosphate (liver functions)-193 H (R 38-126); Creatinine (urinary function) 1.98* (no range given); BUN (urinary function) 22 (no range given).</p> <p>11/24/14 labs: BUN -16, Creatinine-88,</p> <p>11/25/14 labs: AST/SGOT-27, ALT/SGOT - 67, alkaline phosphate- 133 H.</p> <p>All laboratory levels improved with treatment.</p> <p>Resident #54 had an 11/25/14, Hospital Discharge summary, which indicated the resident had received new diagnoses of overdose of narcotic/opiate, renal failure,</p>			

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	<p>acute hypotension. "Hospital course: her first 48 hours here were very sedated. She was given narcan in ER and sat and resp returned to normal. She required low dose dopamine for her hypertension, and we were then able to successfully wean this. Initial urine flow was minimal, but improved with hydration."</p> <p>During a 5/13/15, 1:33 p.m. interview with LPN #8 and the DON, both indicated the QMA accidentally gave Resident #54 the wrong medication. She then contacted LPN #8. LPN #8 contacted the DON. The DON made the call to hold all hypertensive medications and administer the rest of Resident #54's morning medications. Both indicated the physician had not been involved in discussion to administer the routine morning medications.</p> <p>Resident #54 was observed in her room in bed on 5/11/15 at 2:09 p.m. She did not turn towards the speaker or make any form of recognition when called by name. On 5/12/14 at 7:59 a.m., Resident #54 was in a broda chair in her room. She was awake. She did not speak when called by name.</p> <p>A current, undated, facility policy, which was provided by the Administrator on 5/15/15 at 1:10 p.m., indicated the</p>			

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F 354 SS=C Bldg. 00	<p>following:</p> <p>"The medication error will be reported to the attending physician or physician on call for the attending physician as well as the party responsible for the resident."</p> <p>3.1-25(b)(9)</p> <p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.</p> <p>Based on interview and record review, the facility failed to ensure that the services of a Registered Nurse were available 8 hours a day, 7 days a week for the period of time reviewed (3/26/15 through 5/16/15).</p> <p>Findings include: Review of document titled "All Shifts</p>	F 354	<p>F354 WAIVER-RN 8 HRS 7 DAYS/WK FULL-TIME DON</p> <p>The DON & Administrator will ensure that the requirement for daily RN coverage is met. Recruitment efforts began to employ more RN's to satisfy this requirement. All available resources will be utilized to ensure compliance.</p>	06/17/2015	

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F 406 SS=D Bldg. 00	<p>Nurses Time and Work Schedule" indicated that no RN (Registered Nurse) was scheduled on the following dates: 3/28/15, 3/29/15, 5/9/15, and 5/10/15. The schedule indicated that an RN was designated as "on call" 5/9/15 and 5/10/15, but had not worked in the facility on these dates.</p> <p>Review of document titled "Resident Census and Conditions of Residents," provided by the Administrator on 5/12/15, indicated a facility census of 65 residents, with 18 residents receiving injections, 3 residents receiving tube feedings, and 1 resident with an indwelling urinary catheter.</p> <p>During an interview, on 5/18/15 at 1:45 PM, the DON indicated he was aware of the need for an RN to be in the facility for 8 consecutive hours a day, 7 days a week.</p> <p>3.1-17(b)(3)</p> <p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's</p>			

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	<p>comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on observation, interview, and record review, the facility failed to provide socialization and cognitive stimulation for 1 of 1 developmentally disabled residents reviewed for PASRR (Preadmission Screening and Resident Review) Level 2 services. (Resident # 4)</p> <p>Findings include:</p> <p>On 5/14/15 at 8:38 a.m., Resident #4 was seated in her wheelchair in front of the TV in the resident lounge. The TV program was the "Today Show". The resident's eyes alternated between being closed and looking around the room.</p> <p>On 5/14/15 at 10:22 a.m., Resident #4 was in the main dining room, seated in in her wheelchair, during a sing-along activity. She was awake. She was not participating in the activity.</p> <p>On 5/14/15 at 2:37 p.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 05/15/15 at 8:40 a.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 5/15/15 at 10:28 a.m., Resident #4 was observed in bed. She was asleep.</p> <p>On 5/15/15 at 11:16 a.m., Resident #4 was observed in her room sitting in her</p>	F 406	<p>F406 PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</p> <p>The Activity Calendar/Program has been revised to include at least one out of the room daily activity for cognitively impaired dependent residents. The Activity Program will continue to conduct 1:1 visits and attempt to have residents participate in current activity calendar in addition to the specific out of room activity events. The Administrator and Activity Director met to discuss possible activities of interest including sensory groups, porch visits, bird watching, movies, doll therapy, pet therapy, poetry reading, hand massages, musical entertainment, church sessions, and pre-meal socialization to name just a few. The Activity Director and DON/ADON will educate and promote the revised Activity Program to alert nursing staff of daily events and assistance with attendance at said events by cognitively impaired dependent residents. The monthly Activity Calendar will be reviewed by the Administrator. The resident attendance log will be reviewed weekly by the Activity Director &</p>	06/17/2015

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	<p>wheelchair. Her TV was on the same programming as her roommate's TV. The sound on Resident #4's TV was turned off. She was awake.</p> <p>On 5/15/15 at 2:06 p.m., Resident #4 was seated in her wheelchair in her room. She was facing her TV, which was turned off. She was awake.</p> <p>On 5/18/15 at 9:14 a.m., Resident #4 was seated in her wheelchair in her room. She was facing her TV, which was on the same programming as her roommate's TV. The sound on Resident #4's TV was turned off. She was awake.</p> <p>On 05/18/15 at 10:33 a.m., Resident #4 was seated in her wheelchair at "Move and Groove". She was asleep.</p> <p>During an interview on 5/14/15 at 8:49 a.m., CNA #1 indicated that Resident #4 attended Bingo and "Move and Groove" at the facility. She indicated that the resident was not able to actively participate in the activities.</p> <p>During an interview on 5/15/15 at 8:51 a.m., CNA #2 indicated there were no residents on bed rest at the facility.</p> <p>During an interview on 5/15/15 at 8:58 a.m., CNA #3 indicated there were no</p>		<p>Administrator with changes and/or other interventions attempted for poor attendance. The Activity Director will summarize and review the attendance logs at the quarterly QA meeting. The new calendar began June 1, 2015</p>				

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	<p>residents on bed rest at the facility.</p> <p>Resident #4's clinical record was reviewed on 5/13/15 at 1:07 p.m. Resident #4's diagnosis included, but was not limited to, profound intellectual impairment. PASRR review, dated 9/1/14, indicated she met requirements for services.</p> <p>Resident #4 had a current, 3/7/15, annual Minimum Data Set (MDS) which indicated: the resident was moderately cognitively impaired ,and rarely or never made independent decisions, was totally dependent on staff for transfers, and was totally dependent on staff for mobility.</p> <p>Review of document titled "Case Conference Agreement" from the Developmental Disabilities agency, dated 8/22/14, indicated Resident #4's identified needs were "social stimulation and cognitive stimulation."</p> <p>Resident #4 had a current care plan, revised and reviewed on 3/7/15, for encouragement and assistance to attend activities. Interventions included, but were not limited to, the following: " ...Assure that the activities the resident is attending are: Compatible with the residents [sic] physical and mental capabilities ...Compatible with the</p>			

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F 465 SS=C Bldg. 00	<p>residents [sic] individual needs and abilities; and Age appropriate...Engage in simple, structured activities.... "</p> <p>Review of Resident #4 ' s activity attendance record indicated that Resident #4 was sleeping and did not attend any activities on 16 of 31 days in March, 2015, 10 of 30 days in April, 2015, and 1 of 13 days reviewed in May, 2015.</p> <p>3.1-23(1)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure doors and door frames to resident rooms were free of chipped paint, mars, scratches and scuffs for 3 of 3 units reviewed and 47 of 47 residents' rooms reviewed. (Resident rooms 301, 302, 303,305, 306, 307, 309, 310, 311, 312 , 313, 314, 315, 316, 317, 318, 319, 320, 321, 216, 215, 214, 213, 212, 211, 210, 209, 208, 207, 206, 205, 204, 203, 202, 201, 200, 100, 102, 104, 105, 106, 108. 109, 110, 111, 112 and 113)</p>	F 465	<p>F465 SAFE/FUNCTIONAL/SANITARY/COMF ORTABLE ENVIRONMENT</p> <p>A QA plan was initiated on June 1, 2015 to repair the marred & chipped door frames. The QA plan will begin with repainting all of the existing doorframes by June 17, 2015 and then monthly touch up painting thereafter. The QA plan will also include a long term repair plan to strip each door frame of the layers of existing paint down to the base metal frame, then polishing the frame with a stain finish. The</p>	06/17/2015

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	<p>Findings include:</p> <p>During a 5/15/15, 1:44 p.m., environmental tour, the following resident room doors and/or door frames were found to have chipped paint, mars, scratches and scuffs: Rooms 301, 302, 303,305, 306, 307, 309, 310, 311, 312 , 313, 314, 315, 316, 317, 318, 319, 320, and 321 on the 300 hall.</p> <p>During a 5/15/15, 1:44 p.m., environmental tour, the following resident room doors and/or door frames were found to have chipped paint, mars, scratches and scuffs: 216, 215, 214, 213, 212, 211, 210, 209, 208, 207, 206, 205, 204, 203, 202, 201 and 200 on the 200 hall.</p> <p>During a 5/15/15, 1:44 p.m., environmental tour, the following resident room doors and/or door frames were found to have chipped paint, mars, scratches and scuffs: 100, 102, 104, 105, 106, 108. 109, 110, 111, 112 and 113 on the 100 hall.</p> <p>The "Bed Inventory" form, completed by the Administrator on 5/11/15, indicated the 47 certified rooms had the potential to house 92 residents.</p> <p>During a 5/15/15, 1:13 p.m. interview,</p>		<p>project is expected to take up to one year to complete due to the intense procedure for stripping each door frame while continuing to allow access in/out of each room. The maintenance department is responsible for repainting all of the existing door frames and will document the date each door frame is initially completed during the month of June. The maintenance department will then document each month when the door frames are touched up for preventative maintenance. The progress of the QA project will be reviewed quarterly during the QA meeting and updates made accordingly.</p>	

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F 520 SS=E Bldg. 00	<p>the Administrator indicated she had identified a problem with marred and chipped door frames but had yet to establish a plan to correct the problem.</p> <p>3.1-19(f)</p> <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's Quality Assurance</p>	F 520	F520 QAA	06/17/2015

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	<p>Committee failed to implement a plan of action to develop an activity program for cognitively impaired residents. (Residents # 4,12,33,54, & 69)</p> <p>Findings include:</p> <p>During an interview with the Administrator on 5/18/15 at 1:51 p.m., she indicated the QAA committee had not addressed the facility's activity program.</p> <p>Clinical record review, observation and interviews for 5 of 5 residents reviewed for activities during Stage 2 of the survey process (Resident #s 4, 12, 33, 54, 69) indicated the facility failed to provide an activity program to meet the needs of cognitively impaired residents.</p> <p>This deficiency was cited on 7/21/14, and the facility failed to maintain an action plan to correct this deficiency.</p> <p>3.1-52(b)(2)</p>		<p>COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A QA plan was implemented on June 1, 2015 to address the Activity Calendar/Program for cognitively impaired dependent residents. The QA plan includes adding one daily out of the room activity specific for cognitively impaired dependent residents and increased staff awareness & assistance with attendance of these residents in other current activity events. The Activity Director & Administrator met to discuss possible activities of interest including sensory groups, porch visits, bird watching, movies, doll therapy, pet therapy, poetry reading, hand massages, musical entertainment, church sessions, and pre-meal socialization to name just a few. The Activity Director and DON/ADON will educate and promote the revised Activity Program to alert nursing staff of daily events and assistance with attendance at said events by cognitively impaired dependent residents. The monthly Activity Calendar will be reviewed by the Administrator. The resident attendance log will be reviewed weekly by the Activity Director & Administrator with changes and/or other interventions attempted for poor attendance. The Activity Director will summarize and review the attendance logs at the quarterly QA meeting. The new calendar</p>	

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R 000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 10 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.	R 000	began June 1, 2015	
R 214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to complete a pre-admission evaluation for 5 of 5 residents reviewed for admission assessments. Findings include:	R 214	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The 5 residents listed were already residents in the facility prior to licensure effective date. All 5 of these residents will have a pre-admission assessment completed by 06/05/2015 by an LPN and the administrator. How other residents having the potential to be affected by the same deficient practice will be	06/17/2015

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	<p>Resident #1's clinical record was reviewed on 5/18/15 at 10:30 a.m. The clinical record indicated the facility did not complete a pre-admission assessment for this resident.</p> <p>Resident #3's clinical record was reviewed on 5/18/15 at 10:40 a.m. The clinical record indicated the facility did not complete a pre-admission assessment for this resident.</p> <p>Resident #4's clinical record was reviewed on 5/18/15 at 10:55 a.m. The clinical record indicated the facility did not complete a pre-admission assessment for this resident.</p> <p>Resident #5's clinical record was reviewed on 5/18/15 at 11:05 a.m. The clinical record indicated the facility did not complete a pre-admission assessment for this resident.</p> <p>Resident #7's clinical record was reviewed on 5/18/15 at 11:15 a.m. The clinical record indicated the facility did not complete a pre-admission assessment for this resident.</p> <p>Interview with Administrator on 5/18/15 at 11:35 a.m., indicated that the facility believed there was a transition period following licensure and had not</p>		<p>identified and what corrective action(s) will be taken: The remaining 5 residents in the facility also resided in the facility prior to licensure effective date. All 5 of these residents will have a pre-admission assessment completed by 06/05/2015 by an LPN and the administrator. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All future residents will have a pre-admission assessment completed prior to acceptance/admission into the facility by the designated nurse and administrator or designee. 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 The administrator reviews all inquiries prior to acceptance into the licensed assisted living. The administrator will ensure that the pre-admission assessment is completed by the designated nurse before acceptance/admission. The Life Enrichment Coordinator will log all admissions on the Admission Log and document the date of the pre-admission assessment on the log. The log will be reviewed during the quarterly QA meeting for compliance. By what date the systemic changes will be completed June 17, 2015</p>	

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NAME OF PROVIDER OR SUPPLIER COMMUNITY PARKVIEW CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2300 PARKVIEW LN ELWOOD, IN 46036			
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R 216 Bldg. 00	<p>completed the necessary paperwork and assessments for each resident.</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to complete a weight assessment,evaluate the resident's ability to self-administer medications, or obtain chest X-rays for 5 of 5 residents reviewed for clinical record review.</p> <p>Findings include:</p> <p>Resident #R1's clinical record was reviewed on 5/18/15 at 10:30 a.m. The clinical record indicated the facility did not record a weight for the resident, assess the resident's ability to</p>	R 216	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The 5 residents listed were already residents in the facility prior to licensure effective date. All 5 of these residents will have a weight assessment, self- administer medication assessment and chest x-ray completed by 06/17/2015.</p> <p>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:</p>	06/17/2015			

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	<p>self-administer medications, nor obtain a chest X-ray.</p> <p>Resident #R3's clinical record was reviewed on 5/18/15 at 10:40 a.m. The clinical record indicated the facility did not record a weight for the resident, assess the resident's ability to self-administer medications, nor obtain a chest X-ray.</p> <p>Resident #R4's clinical record was reviewed on 5/18/15 at 10:55 a.m. The clinical record indicated the facility did not record a weight for the resident, assess the resident's ability to self-administer medications, nor obtain a chest X-ray.</p> <p>Resident #R5's clinical record was reviewed on 5/18/15 at 11:05 a.m. The clinical record indicated the facility did not record a weight for the resident, assess the resident's ability to self-administer medications, nor obtain a chest X-ray.</p> <p>Resident #R7's clinical record was reviewed on 5/18/15 at 11:15 a.m. The clinical record indicated the facility did not record a weight for the resident, assess the resident's ability to self-administer medications, nor obtain a chest X-ray.</p>		<p>The remaining 5 residents in the facility also resided in the facility prior to licensure effective date. All 5 of these residents will have a weight assessment, self-administer medication assessment and chest x-ray completed by 06/17/2015.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>All future residents will have a weight assessment, self-administer medication assessment and chest x-ray completed prior to or upon admission into the facility.</p> <p>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</p> <p>The administrator or designee will perform an admission chart audit for compliance with the weight assessment, the self-administer medication assessment and chest x-ray upon admission to ensure that these tasks are completed. The admission chart audit will be documented on the Admission Chart Audit log and reviewed at the quarterly QA meeting for compliance</p> <p>By what date the systemic changes will be completed</p>	

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R 408 Bldg. 00	<p>Interview with Employee #11 on 5/18/15 at 10:35 a.m., indicated that all residents self-administered their medications and the facility did not weigh the residents.</p> <p>Interview with the Administrator, on 5/18/15 at 11:35 a.m., indicated the facility believed they had a transition period following licensure and had not completed all of the necessary paperwork and assessments for each resident.</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to obtain chest X-rays for 5 of 5 residents reviewed for clinical record review. (Residents R1, R3, R4, R5, & R7)</p> <p>Findings include:</p> <p>Resident #R1's clinical record was reviewed on 5/18/15 at 10:30 a.m. The clinical record indicated the facility did not obtain a chest X-ray within six months previous to admission.</p>	R 408	<p>June 17, 2015</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>The 5 residents listed were already residents in the facility prior to licensure effective date. All 5 of these residents will have a chest x-ray completed by 06/17/2015.</p> <p>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:</p> <p>The remaining 5 residents in the</p>	06/17/2015

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	<p>Resident #R3's clinical record was reviewed on 5/18/15 at 10:40 a.m. The clinical record indicated the facility did not obtain a chest X-ray within six months previous to admission.</p> <p>Resident #R4's clinical record was reviewed on 5/18/15 at 10:55 a.m. The clinical record indicated the facility did not obtain a chest X-ray within six months previous to admission.</p> <p>Resident #R5's clinical record was reviewed on 5/18/15 at 11:05 a.m. The clinical record indicated the facility did not obtain a chest X-ray within six months previous to admission.</p> <p>Resident #R7's clinical record was reviewed on 5/18/15 at 11:15 a.m. The clinical record indicated the facility did not record a weight for the resident, assess the resident's ability to self-administer medications, nor obtain a chest X-ray within six months prior to admission.</p> <p>Interview with the Administrator, on 5/18/15 at 11:35 a.m., indicated the facility believed they had a transition period following licensure and had not completed all of the necessary paperwork and assessments for each resident.</p>		<p>facility also resided in the facility prior to licensure effective date. All 5 of these residents will have a chest x-ray completed by 06/17/2015.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>All future residents will have a chest x-ray completed prior to or upon admission into the facility.</p> <p>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</p> <p>The administrator or designee will perform an admission chart audit for compliance with the chest x-ray upon admission to ensure that these tasks are completed. The admission chart audit will be documented on the Admission Chart Audit log and reviewed at the quarterly QA meeting for compliance</p> <p>By what date the systemic changes will be completed</p> <p>June 17, 2015</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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