

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/19/2013
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NAME OF PROVIDER OR SUPPLIER  WESLEY MANOR HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1555 N MAIN ST FRANKFORT, IN 46041
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 10, 11, 12, 13, 14, 17, 18 &amp; 19, 2013</p> <p>Facility number: 001152 Provider number: 155658 AIM number: 200221050</p> <p>Survey team: Michelle Carter, RN-TC (6/10, 6/11, 6/12, 6/17, 6/18 &amp; 6/19, 2013) Rita Mullen, RN Bobette Messman, RN (6/11, 6/12, 6/13, 6/14, 6/17, 6/18, 6/19, 2013) Sandra Nolder, RN (6/10, 6/11, 6/12, 6/13, 6/17, 6/18 &amp; 6/19, 2013)</p> <p>Census bed type: SNF/NF: 85 Residential: 124 Total: 209</p> <p>Census Payor Type: Medicare: 5 Medicaid: 40 Other: 164 Total: 209</p>	F000000	<p>Submission of this plan of correction shall not constitute or be construed as an admission that Wesley Manor, Inc. provides anything other than a high quality of care to its residents. Wesley Manor considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us regarding potential needs to improve our services should be taken very seriously, and we are committed to using our resources to make any needed improvements necessary to achieve better outcomes for residents.</p> <p>As required, the facility submits the following plan of correction:</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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on 6/22/13.</p>			
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F000156 SS=A	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>				

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>			

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	<p>and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to provide liability and appeal notices for 1 of 3 residents reviewed for liability and appeals notices in a sample of 3. (Resident #112)</p> <p>Findings include:</p> <p>The clinical record of Resident #112 was reviewed, on 6/13/13 at 1:30 p.m. The resident was admitted on 12/28/13 and discharged to home on 1/8/13.</p> <p>Resident #112 did not have a liability and appeal notice for discharge.</p> <p>During an interview with the administrator, on 6/13/13, at 4:00 p.m., the administrator indicated that the facility could not locate the appropriate liability and appeal notice for resident # 112.</p> <p>3-1.4(f)(3)</p>	F000156	<p>This tag was cited due to one resident's record not including a copy of the notice of discontinuation of Medicare skilled nursing facility coverage.</p> <p>Resident #112 is discharged to another level of care within the facility once his rehabilitation program helped him to return to his prior level of function and all goals for discharge were met. He has been interviewed to make certain that he fully understood the reasons his services were discontinued, and has been informed that any time he has Medicare funded services discontinue, that he has appeal rights.</p> <p>In order to identify any other residents who might be impacted by this problem, Medical Records staff will audit the records for all residents who had Medicare services discontinued over the last 90 days (Attachment O) to make certain that they received a notice of discontinued coverage and that they were given notice of their appeal rights.</p> <p>Medical Records staff will include an audit for the notice of discontinued coverage in their audit of closed charts after discharge (Attachment P). These audits will be for all charts and will go on indefinitely.</p>	07/19/2013

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			<p>The notice is provided at the final care plan conference held prior to the resident's discharge from the skilled nursing facility. This practice will continue.</p> <p>Social Services staff have received additional training regarding this plan of correction and residents' rights to appeal discontinued coverage.</p> <p>All corrections for this tag will be completed by July 19, 2013.</p>	

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F000309 SS=D	<p><b>483.25</b>  <b>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to follow the policy and procedure for monitoring of bowel movements for 1 of 10 residents reviewed for bowel monitoring in a sample of 10. (Resident #96)</p> <p>Findings include:</p> <p>The clinical record of Resident #96 was reviewed on 6/12/13 at 10:30 a.m.</p> <p>Diagnosis included, but were not limited to, dementia with agitation, depression, high blood pressure, hyperlipidemia, anxiety, bipolar affective disorder and constipation.</p> <p>A Care Plan for pain, dated 5/7/13, indicated due to pain medication the resident's bowel movements were to be monitored and recorded daily.</p> <p>A Bowel and Bladder report, dated for the month of May 2013, indicated on</p>	F000309	<p>This tag was cited due to protocol for monitoring bowel movements not being followed for 1 resident (#96).</p> <p>Resident #96, who does toilet her self independently, is known to protest staff's requests to know whether or not she has had a bowel movement. When it is unknown whether she has had a bowel movement, the staff will record that she has not had one. In order to correctly follow the protocol for monitoring of resident #96's bowel function, staff will make certain to assess and record bowel sounds, as well as record intake of food and fluids. Her plan of care (Attachment A) has been modified to include person-centered interventions for assisting her to maintain healthy bowel function.</p> <p>Other residents who might potentially be impacted by lack of monitoring bowel function will be identified through audits of the daily reports for residents who have not had a bowel movement for 3 days. This is a</p>	07/19/2013	

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	<p>5/15/13 Resident #96 had not had a bowel movement in 3 days. The report also indicated the resident did not have a bowel movement until 5/20/13. This was seven days without a bowel movement.</p> <p>A review of Nursing notes, for 5/15/13 through 6/20/13, did not indicate a bowel assessment had been done.</p> <p>A Medication Administration Record [MAR], dated for the month of May 2013, indicated resident #96 received milk of magnesia [MOM] 30 milliliters [ml] on 5/15/13 (no time indicated). A follow-up notation indicated the resident did not have results from the MOM.</p> <p>The MAR for May 2013, indicated Resident#96 received MOM 30 ml, on 5/16/13 (no time indicated). There was no indication the MOM was effective. No other interventions were indicated.</p> <p>During an interview with the Assistant Director of Nursing, on 6/19/13 at 9:30 a.m., he indicated the MAR, for May 2013, did not indicate other interventions were initiated to promote a bowel movement nor did the nursing notes.</p>		<p>computerized report that identifies residents who potentially require intervention for poor bowel function. The D.O.N. and A.D.O.N. (or their designee) will monitor these reports during daily rounds to determine whether facility protocol was followed for interventions required on the previous day. The reports will be attached to the 24-hour shift-to-shift report for that day and will be initialed by the D.O.N. and/or A.D.O.N. once reviewed, and will also be marked with a "+" if appropriate follow-up occurred. These daily audits will continue for 30 days or until it is determined that protocol is being consistently followed.</p> <p>Daily audits will continue for one month and, thereafter, a monthly quality assurance audit (Attachment B) will be performed to assure that compliance continues. This audit will continue for at least one year but may be continued or modified according to the D.O.N.'s findings.</p> <p>All nurses will receive in-service training regarding the facility's policy for monitoring and documentation of bowel function (Attachment C).</p> <p>All corrections for this tag will be completed by July 19, 2013.</p>				

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	<p>A Policy and Procedure for "Monitoring of Bowel Movement, dated 4/20/01, received from the Assistant Director of Nursing, on 6 /19/13 at 9:30 a.m., indicated the following:</p> <p>"...Procedure:</p> <ol style="list-style-type: none"> <li>1. CNA's [certified nursing assistant] document amount every shift on CNA Resident Record</li> <li>2. Charge nurse ensures completion of data every shift</li> <li>3. 7-3 shift nurse audit daily and lists anyone with no BM [bowel movement] x 3 days and assure resident has order to prn [as needed] laxative. If no order, notify physician of need.</li> <li>4. 3 -11 shift administers prn laxative to soften stool.</li> <li>5. If no BM by following 7-3 shift, suppository or enema is to be given as ordered by physician.</li> <li>6. All shifts responsible for documenting results."</li> </ol> <p>3.1-37(a)</p>				

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to cover and date items in the walk-in refrigerator, ensure the sanitation sink was at the proper pH and items on the drying rack were kept clean for 2 of 2 main kitchen observations. This had the potential to affect 85 of 85 residents.</p> <p>Findings include:</p> <p>1. During the initial tour of the main kitchen, on 6/10/13 at 10:00 a.m., the following items were found in the main kitchen walk-in refrigerator, uncovered and not dated:</p> <p>28 small bowls of fruit</p> <p>33 salads</p> <p>58 slices of cream pie</p> <p>During an interview with Dietary employee #3, on 6/10/13 at 10:15 a.m., it was indicated those items were for the salad bar for lunch and</p>	F000371	<p>This tag was cited due to (1) not covering and dating all items in a walk-in refrigerator, (2) kitchen equipment not cleaned (3) The sanitation sink's concentration level of sanitizer not reaching 200 ppm.</p> <p>There were no specific residents mentioned in this tag, and all residents are identified as potentially impacted.</p> <p>The facility will correct this problem by: 1.Food Storage:</p> <p>A. Educating all Dietary staff regarding the facility's policies for safe storage of foods not being served immediately (Attachment D)</p> <p>1.Having the Director of Dining Services and/or the R.D. conduct weekly inspections of the kitchen at an unannounced time in order to make certain food items in the refrigerators are covered and dated. These inspections will be documented on a sanitation audit form (Attachment E).</p>	07/19/2013	

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	<p>were not covered or dated.</p> <p>2. During a follow up tour of the Main Kitchen with the Dietary Manager, on 6/14/13 at 8:45 a.m., the following items were found:</p> <p>There was grease spilled on the side of a clear plastic food prep/storage bin container sitting on the drying rack.</p> <p>Dust and grease on the back of the grill.</p> <p>The sanitation sink of the three part sink did not test at the required pH of 200 ppm (parts per million).</p> <p>During an interview with the Dietary Manager, on 6/14/13 at 9:15 a.m., she indicated the repairman for the sanitation sink would be called, the back of the grill needed to be cleaned and she should have seen the grease on the storage bin of the drying rack.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>1.Kitchen Equipment Cleaning:</p> <p>A. Educating Dietary staff regarding the cleaning schedules for all kitchen equipment and the appropriate standards of cleanliness.</p> <p>1.Having the Director of Dining Services and the R.D. conduct weekly inspections of the kitchen at an unannounced time in order to make certain all equipment is appropriately cleaned (including the grill and the containers on the drying racks). These inspections will be documented on a sanitation audit form (Attachment E).</p> <p>1.Sanitizer Levels in the Sanitation Sink:</p> <p>A. In-service instruction of all staff who work at the sanitation sink, or who may become responsible for the sanitation sink, regarding the required levels of QT sanitizer as measured in parts per million. For the current product (Array, Ultimate Sanitizer) the appropriate level is 200 ppm as measured in water between 65 &amp; 75 degrees. Upon inspection by the vender who supplies this product and mechanically sets the flow rate into the sanitation sink, the product is being distributed to the sink correctly as it does measure at 200 ppm. The Administrator visited this sink on</p>		

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			<p>6/26/13 and measured the amount of sanitizer with the appropriate test strip and it did measure at 200 ppm. Upon interview with the staff member present during the survey, she stated that she did not believe she held the test strip in the solution for a full minute prior to looking at the color of the strip. She also indicated warm water was in the sanitation sink.</p> <p>B. Directions for the use of test strips as well as full instructions for sanitizing all items that are cleaned in this area are more concretely articulated in the revised policy for the sanitation area (Attachment F).</p> <p>C. A tracking sheet (Attachment G) for monitoring the concentration of sanitizer in the sanitation sink will be kept with the daily cleaning checklist on the clipboard adjacent to the sanitation sink. This sheet will be audited with all routine kitchen sanitation inspections (Attachment E) and the ppm will be measured by the individual inspecting the area at the time of the audit.</p> <p>Quality assurance audits mentioned above will occur weekly until items requiring correction are found to be in compliance for 4 consecutive audits. Thereafter, monthly</p>		

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			audits will occur and will continue indefinitely.  All corrections for this tag will be completed by July 19, 2013.	

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F000431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to provide separately locked, permanently affixed compartments for storage of</p>	F000431	This tag was cited due to the facility not having medications that required both a double lock and refrigeration, double locked.	07/19/2013			

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	<p>controlled drugs in 3 of 4 medication storage areas.</p> <p>Findings include:</p> <p>Medical storage areas were observed on 6/12/2013 and the following observations were made:</p> <p>On 6/12/2013, at 10:50 a.m., on F floor, Lorazepam (anti-anxiety) oral concentrate was in the unlocked refrigerator. The refrigerator was located in the locked medication storage area.</p> <p>On 6/12/2013, at 11:08 a.m., on H hall, Lorazepam oral concentrate was in a locked refrigerator. The refrigerator was located at the nursing station on an unlocked unit.</p> <p>On 6/12/2013, at 11:20 a.m., on G hall, Lorazepam oral concentrate was in a locked refrigerator. The refrigerator was located at the nurses station on an unlocked unit.</p> <p>During an interview with LPN #4, on 06/12/2013, at 11:10 a.m., she indicated that the refrigerator on the H hall cannot fit in the medication storage area for the unit.</p> <p>During an interview with LPN #2, on</p>		<p>No residents were impacted by this problem, however, residents on 3 units could have potentially been impacted by this problem.</p> <p>The facility will correct this problem for all residents who would have potentially been impacted by this problem by creating space for the locked refrigerators on Units G &amp; H to be enclosed in the locked medication room (thus creating a double-lock), and by requiring the refrigerators used to store medications on unit F to be locked and kept in the locked medication rooms.</p> <p>Staff on all units will be re-educated regarding the facility's policy to double-lock all schedule two medications (Attachment H)</p> <p>During environmental audits (Attachment I), the Administrator and/or his designee will audit each medication refrigerator to determine whether controlled medications are double-locked per policy. These audits will occur monthly for the next three months and frequency will be re-determined thereafter.</p> <p>All corrections for this tag will be completed by July 19, 2013.</p>				

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	<p>06/12/2013, at 11:25 a.m., she indicated that the refrigerator on the G hall cannot fit in the medication storage area for the unit.</p> <p>During an interview with the Assistant Director of Nursing, on 06/12/2013, at 11:30 a.m., he indicated Lorazepam oral concentrate should be double locked on all units, at all times.</p> <p>3.1-25(n)</p>				

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F000514 SS=D	<p>483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to document a resident's bowel movements and a resident's allergies on the Medication Administration Record for 2 of 40 residents reviewed for accuracy of documentation, (Resident #42 and 96) and failed to ensure a fall risk assessment was completed for 1 of 3 residents reviewed for accidents. (Resident #122).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #42 was reviewed on 6/13/13 at 10:30 a.m.</p> <p>A physician's office instructions/orders, dated 3/26/13,</p>	F000514	<p>This tag was cited due to lack of documentation of bowel movements for one resident, lack of documentation regarding allergies for one resident, and inaccurate completion of a fall risk assessment for one resident.</p> <p>This problem was corrected for resident #122 by having her nurse amend the fall risk assessment (Attachment J) to include her history of falls prior to admission. According to the assessment all necessary interventions are in place and appropriately included in the plan of care (Attachment K).</p> <p>This problem was corrected for resident #96 by assessing her bowel function and accurately recording her bowel movements and/or interventions made to promote healthy bowel function.</p>	07/19/2013	

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	<p>indicated Resident #42 was allergic to ampicillin (antibiotic), elavil (antidepressant), motrin (pain medication) and trazodone (antidepressant).</p> <p>A Physician's summary, dated 5/20/13 indicated Resident #42 had no allergies.</p> <p>An allergy sticker on the inside front of chart indicated Resident# 42 was allergic to ampicillin.</p> <p>A Medication Administration Record (MAR), dated for the month of May 2013, indicated Resident #42 had no known allergies.</p> <p>During an interview with LPN #4, on 6/13/13 at 11:10 a.m., she indicated the allergies should have been faxed to the pharmacy so they would appear on the MAR.</p> <p>2. The clinical record of Resident #96 was reviewed on 6/12/13 at 10:30 a.m.</p> <p>Diagnosis included, but were not limited to, dementia with agitation, depression, high blood pressure, hyperlipidemia, anxiety, bipolar affective disorder and constipation.</p>		<p>Her plan of care has been updated to reflect interventions necessary to promote healthy bowel function (Attachment A).</p> <p>This problem was corrected for resident #42 by clarifying the resident's allergies with her physician and her family. Allergy information has been transferred to her physician's orders (Attachment L) and to her medication administration record (Attachment M).</p> <p>In order to identify any other residents who might potentially be impacted by this problem, the facility will audit 8 residents' records per month for history of allergies, documentation of bowel function, and accurate completion of assessments (Attachment N).</p> <p>Nurses will receive in-service education regarding:</p> <ul style="list-style-type: none"> <li>·The need to make certain information regarding residents' allergies are brought forward from physicians' records to the M.A.R. and the monthly order summary.</li> <li>·Accurate completion of assessments and the need to research resident history that might be available in documents generated prior to admission (i.e. hospital records)</li> <li>·Recording of bowel movements and the interventions taken to promote healthy bowel function.</li> </ul>				

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	<p>A Care Plan for pain, dated 5/7/13, indicated due to pain medications bowel movements were to be monitored and recorded daily.</p> <p>A Bowel and Bladder report, dated for the month of May 2013, indicated on 5/15/13 Resident #96 had not had a bowel movement in 3 days. The report also indicated the resident did not have a bowel movement until 5/20/13.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 6/19/13 at 9:30 a.m., he indicated he had contacted CNA (Certified Nursing Assistant) #5, on 6/14/13 at 3:54 p.m. She indicated to the ADoN she had not enter Resident #96's two small bowel movements into the care tracker system during 5/15/13 through 5/20/13.</p> <p>A Policy and Procedure for "Monitoring of Bowel Movement, dated 4/20/01, received from the Assistant Director of Nursing, on 6 /19/13 at 9:30 a.m. indicated the following:</p> <p>"...Procedure: 1. CNA's [certified nursing assistant] document amount every shift on CNA Resident Record...."</p>		All corrections for this tag will be completed by July 19, 2013.		

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	<p>3. The clinical record for Resident #122 was reviewed on 6/14/2013 at 10:30 a.m.</p> <p>Diagnoses for Resident #122 included, but were not limited to, hypertension, congestive heart failure, depression, dementia, chronic back pain, diabetes, osteoarthritis, osteoporosis, constipation, incontinence, lumbar diskitis, and hyponatremia.</p> <p>The pre-fall assessment form, dated 5/16/13, and the readmission pre-fall assessment form, dated 6/10/2013, did not indicate a history of falls for Resident #122.</p> <p>A fall assessment record, dated 5/22/13, and an additional fall assessment record, dated 5/30/13, indicated Resident #122 had a history of falls prior to admission (no date was indicated). The resident fell within 2-6 months prior to admission (no date was indicated) and a had fracture, related to a fall, (no date was indicated) within six months prior to facility admission.</p> <p>No documentation indicating information regarding a fall or fracture was documented in Resident #122's</p>						

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	<p>clinical record.</p> <p>No fall assessment for readmission to the facility on 6/10/13 was noted in Resident #122's clinical record.</p> <p>A history and physical admission note to the hospital, dated 06/05/13, indicated " approximately 4 weeks ago , the patient noted an episode of falling from standing and landing on her side"</p> <p>During an interview with LPN #1 and the Assistant Director of Nursing (ADON), on 06/14/13, at 3:00 p.m., they indicated no information was obtained/documentated related to recent falls and indicated the fall assessments were not completed, properly.</p> <p>3.1-31(a)(c)(1)</p>				

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R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5.	R000000	Submission of this plan of correction shall not constitute or be construed as an admission that Wesley Manor, Inc. provides anything other than a high quality of care to its residents. Wesley Manor considers itself to be a partner with the Indiana State Department of Health and other entities in an ongoing effort to continually improve the services provided in long term care facilities. We believe that any feedback provided to us regarding potential needs to improve our services should be taken very seriously, and we are committed to using our resources to make any needed improvements necessary to achieve better outcomes for residents.  As required, the facility submits the following plan of correction:		

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R000144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the environment was free of needed repairs and cleaned, for 1 of 1 environmental tour observations .</p> <p>Findings include:</p> <p>The facility was toured on 6/13/13, at 2:15 P.M., with the Executive Director (ED). During the tour, bugs and insects were visibly noted in light coverings in the following areas:</p> <ol style="list-style-type: none"> <li>1. 40 of 63 light coverings on the A hall, 200 floor</li> <li>2. 22 of 54 light coverings on the B hall, 200 floor</li> <li>3. 22 of 49 light coverings on the C hall, 200 floor</li> <li>4. 9 of 62 light coverings on the D hall, 200 floor</li> <li>5. 12 of 54 light coverings on the E hall, 200 floor</li> <li>6. 10 of 61 light coverings on the F hall, 200 floor</li> </ol> <p>Holes in ceiling tiles and broken ceiling tiles were noted on the following hallways:</p>	R000144	<p>This tag was cited due to dead bugs (i.e. flies) noted in light coverings, damaged ceiling tiles, and damaged light coverings.</p> <p>No residents were mentioned in this citation. However, all residents using the area have the potential to be impacted. The facility will correct this problem as follows:</p> <ol style="list-style-type: none"> <li>1. The Housekeeping and Maintenance staff have cleaned the light coverings and removed all debris/bugs.</li> <li>2. The Facility Services Director has contacted a vendor to replace the ceiling tiles that a noted to have damage.</li> <li>3. The Facility Services Director has contacted a vendor to replaced the damaged light coverings.</li> </ol> <p>In order to monitor for this problem developing again, the facility will complete environmental audits (Attachment I) which includes examination of light fixtures and ceiling tiles. These audits will be completed monthly over the next 90 days, then quarterly thereafter indefinitely.</p>	07/19/2013	

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	<p>1. A hall, 200 floor 2. B hall, 200 floor 3. C hall, 200 floor 4. D hall, 200 floor</p> <p>Brown colored stains were noted on ceiling tiles on the following hallways:</p> <p>1. A hall, 200 floor 2. E hall, 200 floor</p> <p>Three broken and cracked light coverings were noted on the A hall, 200 floor.</p> <p>During an interview, with the ED, on 6/13/13 at 2:15 P.M., he indicated the lights and ceiling tiles were supposed to be cleaned and repaired, when needed. He indicated he would contact the maintenance department for the needed repairs and cleaning.</p>		<p>Staff in the Maintenance and Housekeeping departments will be in-serviced regarding the need to call attention to these environmental issues and to intervene as necessary to correct any identified problems.</p> <p>Corrections for this tag will be completed by July 19, 2013.</p>		

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R000217	<p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on clinical record review and interview, the facility failed to update a service plan for 1 of 9 residents reviewed for service plans in a sample of 9. (Resident #127)</p> <p>Findings include:</p>	R000217	<p>This tag was cited due to one resident's service plan not being updated to include all current services.</p> <p>This problem was corrected for resident #127 by meeting with the resident and her IDT to make sure all needed services are included on her Service Plan.</p>	07/19/2013	

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	<p>The clinical record for Resident #127 was reviewed on 6/18/13 at 1:10 p.m.</p> <p>Resident #127's diagnoses included, but were not limited to, depression, history of transient ischemic attack versus cerebral vascular accident, diabetes, anemia, renal failure, malignant renal hypertension, osteoarthritis, sciatica and chronic kidney disease.</p> <p>The service plan for Resident #127 was dated 10/16/12. Physician orders, dated 3/13/13, indicated Resident #127 was to receive hospice services. Evidence of an updated service plan to reflect hospice services was not found.</p> <p>During an interview with the Executive Director, on 6/18/13 at 4:15 P.M., he indicated Resident #127's service plan should have been updated to reflect hospice services, and it was not.</p>		<p>This problem occurred because the required 6-month review date was missed. In order to identify any other residents' potentially impacted by this problem, and audit will be performed by the facility to examine all Service Plans and make sure their reviews are timely.</p> <p>In addition, the facility has revised the Service Plan form (Attachment Q) to prompt staff to list any ancillary services provided to the resident. The new form will be added as residents become due for reviews.</p> <p>A quarterly quality assurance audit (Attachment R) will be performed in order to determine if all Service Plans are timely and complete. Audits will continue until compliance is 100% for 2 consecutive quarters.</p> <p>Nurses in the residential facility will receive in-service education regarding the new form and procedures for reviewing Service Plans.</p> <p>All corrections for this tag will be completed by July 19, 2013.</p>		

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R000246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure medications specified with a PRN (as needed) physician order were authorized for administration by a nurse, prior to administration by a qualified medication assistant (QMA). This deficiency affected 1 of 9 residents, in a sample of 9, reviewed for PRN (as needed) medications. (Resident #127)</p> <p>Findings include:</p> <p>The clinical record for Resident #127 was reviewed on 6/18/13 at 11:00 A.M.</p> <p>Resident #127's diagnoses included, but were not limited to, depression, history of transient ischemic attack versus cerebral vascular accident, diabetes, anemia, renal failure, malignant renal hypertension,</p>	R000246	<p>This tag was cited due to there being no documentation to support that a QMA received authorization from a licensed nurse to administer a PRN (as needed) medication to one resident.</p> <p>The problem will be corrected for resident # 127 and any other resident with potential to be impacted as follows:</p> <ul style="list-style-type: none"> <li>·QMA's and Nurses will receive in-service education to remind them of the requirement to obtain authorization from the nurse and to document this authorization in the nurse's notes.</li> <li>·During monthly audits of the medication administration records, audits will include evaluation of the documentation to support that PRN's given by QMA's were authorized by a licensed nurse.</li> <li>·These audits will be performed for at least 10 residents who received PRN medications</li> </ul>	07/19/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155658	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/19/2013
NAME OF PROVIDER OR SUPPLIER  WESLEY MANOR HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1555 N MAIN ST FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>osteoarthritis, sciatica and chronic kidney disease.</p> <p>A physician's order, dated 11/17/10, indicated Hydrocodone (narcotic pain medication) 5/500 mg (milligrams), one tablet, every four hours, PRN (as needed), for pain.</p> <p>The March 2013 Medication Administration Record (MAR) indicated Resident #127 received Hydrocodone 5/500 mg. on 3/11/13 at 4:00 A.M., and on 3/13/13 at 7:30 A.M. The pain medications were administered by a QMA, as indicated on the MAR. Nurse authorization for administration was not evidenced in Resident #127's clinical record.</p> <p>During an interview with the nurse unit manager on 6/18/13 at 11:35 A.M., she verified the pain medications were administered by a QMA and nurse authorization was not received prior to administration.</p>		<p>administered by a QMA. (Attachment S).</p> <p>All corrections for this tag will be completed by July 19, 2013.</p>		