

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/26/2015
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NAME OF PROVIDER OR SUPPLIER PARK TERRACE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00175631.</p> <p>Complaint IN00175631- Substantiated. Federal/State deficiencies related to the allegation are cited at F278, F280, F315, and F356.</p> <p>Survey dates: June 25 and June 26, 2015</p> <p>Facility number: 000221 Provider number: 155328 AIM number: 100267620</p> <p>Census bed type: SNF/NF: 75 Total: 75</p> <p>Census Payor type: Medicare: 17 Medicaid: 50 Other: 8 Total: 75</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1</p>	F 0000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after July 26th, 2015.</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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F 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement. Based on record review and interview the facility failed to ensure that the Minimum Data Set assessment was accurate related</p>	F 0278	F 278 SS --D -whatcorrective action(s) will be accomplished for those residents found to havebeen affected by	07/26/2015

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	<p>to urinary tract infections and falls with major injury for 1 of 4 residents reviewed for urinary tract infections and 1 of 2 residents reviewed for falls with major injury. (Resident #4007 and #4004)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #4007 was reviewed on 6/26/2015 at 10:50 a.m. Diagnoses included, but were not limited to, anemia, diabetes, and urinary tract infection.</p> <p>The quarterly Minimum Data Set (MDS) assessment, with reference date 4/30/2015, indicated that the resident had a diagnosis of urinary tract infection.</p> <p>The clinical record did not indicate any significant laboratory findings, medication or treatment of a urinary tract infection, or signs and symptoms attributed to urinary tract infection.</p> <p>During an interview on 6/26/15 at 2:00 p.m., MDS Coordinator #5, indicated the quarterly assessment was not coded accurately for diagnosis of urinary tract infection.</p> <p>2. The clinical record for Resident #4004 was reviewed on 6/25/2015 at 11:46 a.m. Diagnoses included, but were not limited</p>		<p>the deficient practice</p> <p>Resident#4007 – MDS was modified to reflect accurate coding related to UTI</p> <p>Resident # 4004 – MDS was modified to reflect accurate coding related to fall with major injury</p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken</p> <p>All residents who have a urinary tractinfection, or have had a fall with injury have the potential to be affected.MDS assessments for residents who had a UTI and/or fall with injury care planswill be reviewed for accuracy by the MDS Coordinator.</p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur</p> <p>TheRAI Specialist will provide education to the MDS Coordinator and Assistantregarding accurate coding of the MDS on or by July 24 2015.</p> <p>MDSCoordinator will check the accuracy of resident with UTI and falls with injuryto ensure MDS is accurate.</p> <p>·howthe corrective action(s) will</p>				

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F 0280 SS=D Bldg. 00	<p>to, anemia, tremors, Alzheimer's disease, and fracture of the right shoulder and the left knee.</p> <p>The significant change in status Minimum Data Set (MDS) assessment, with reference date 4/27/2015, indicated the resident did not have a fall with major injury.</p> <p>The clinical record indicated Resident #4004 had a fall on 4/22/2015 that resulted in a fracture of the right shoulder and the left knee.</p> <p>During an interview on 6/26/2015 at 10:35 a.m., MDS Coordinator #5, indicated that the significant change in status assessment was not coded accurately for falls.</p> <p>This Federal tag relates to Complaint IN00175631</p> <p>3.1-31(i)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <p>The RAI Process CQI tool will be completed by the MDS Coordinator weekly times 4, monthly x 6 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p> <p>·by what date the systemic changes will be completed. July 26, 2015</p>		

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	<p>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 interview and record review, the facility failed to revise care plans for 1 of 7 residents reviewed for psychoactive medications and 2 of 3 residents reviewed for pressure ulcers in a sample of 10. (Residents #4001, 4002, and 4005)</p> <p>1. The clinical record for Resident #4005 was reviewed on 6/25/2015 at 11:45 a.m. Diagnoses included, but were not limited to, anemia, Parkinson's, arthritis, fibromyalgia, and depression.</p> <p>The Skin Integrity Assessment: Prevention and Treatment care plan was initiated 6/2/2015 for Resident #4005 and identified a problem of alteration in skin integrity. The care plan goals were for the wounds to demonstrate healing without</p>	F 0280	<p>F 280 SS- - D</p> <p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;</p> <p>Thecare plans for residents #4005, 4001 and 4002 were revised to reflectmeasureable goals and interventions specific for the resident.</p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken;</p> <p>Residentswith pressure wounds and/or receiving psychotropic medications have thepotential to be affected. The care plansfor these residents will be reviewed and revised as indicated for</p>	07/26/2015			

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	<p>signs and symptoms of infection and for the resident to cooperate with position changes.</p> <p>During an interview on 6/26/2015 at 1:10 p.m., Certified Nurse Aide (CNA) #3, indicated the resident did cooperate with position changes, however had specific positions in which she wanted to be turned in order for her to be comfortable.</p> <p>During an interview on 6/26/2015 at 2:20 p.m., Resident #4005, indicated she never refused to be turned. The resident indicated she had to be positioned in certain ways that were the most comfortable for her.</p> <p>The current care plan goal for the resident to cooperate with position changes was not measurable and was not updated to reflect current information relative to the resident's care and treatment.</p> <p>During an interview on 6/26/2015 at 2:30 p.m., Minimum Data Set (MDS)Coordinator #5, indicated the care plan goal had not not been updated to reflect a goal that was specific to the resident's care and treatment and that the care plan goal was not measurable.</p> <p>2. The clinical record for Resident</p>		<p>pressureulcers and psychotropic medications by DNS/designee.</p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>TheRAI Specialist or designee will provide education on reviewing/revising thecare plans for residents with pressure wounds and/or psychotropic medicationsto the Interdisciplinary Team on or before July 24 2015.</p> <p>Forresidents with pressure wounds, the care plan will be reviewed and revised weeklyby the Interdisciplinary Team to ensure care plans are accurate.</p> <p>Forresidents with psychotropic medications, the care plan will be reviewed andrevised at least quarterly by the Social Services director or designee and whenthere is a change in medication and/or a change in mood/behavior.</p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place</p> <p>TheDNS/designee will complete the Care Plan Updating CQI tool weekly x 6</p>		

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	<p>#4001 was reviewed on 6/26/2015 at 8:30 a.m. Diagnoses included, but were not limited to, anemia, quadriplegia, neurogenic bladder, and anxiety disorder.</p> <p>The Skin Integrity Assessment: Prevention and Treatment care plan, with last review date of 3/25/2015, indicated a problem of the resident being at risk for skin breakdown.</p> <p>The clinical record indicated resident had six pressure ulcers that were initially identified between 4/8/2015 and 5/11/2015.</p> <p>The Skin Integrity Assessment: Prevention and Treatment care plan was not updated to reflect the current status of the resident having pressure ulcers.</p> <p>During an interview on 6/26/2015 at 10:10 a.m., Minimum Data Set Coordinator #5, indicated the care plan had not been updated to reflect the pressure ulcers.</p> <p>3. The clinical record for Resident #4002 was reviewed on 6/25/2015 at 2:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, Parkinson's disease, and anxiety disorder.</p> <p>The clinical record indicated Resident</p>		<p>months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p> <p>by what date the systemic changes will be completed. July 26, 2015</p>				

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	<p>#4002 had an order for Ativan (antianxiety medication) 0.25 milligrams (mg)orally twice daily as needed for anxiety. The clinical record indicated that, on 5/26/2015, the dosage of Ativan was increased to 0.5 mg orally twice daily on a routine basis.</p> <p>The Mood and Behavior Symptom Assessment/Plan of Care for psychotropic drug use, reviewed 4/16/2015, indicated a problem of psychotropic drug use and identified the drug as Ativan 0.25 mg twice daily as needed. The problem indicated a diagnosis of anxiety and a behavior symptom that the drug was intended to treat was anxiousness. The care plan goal was for the resident to have no negative outcomes resulting from use of psychotropic medications. The care plan interventions included, but were not limited to, monitor for side effects, monitor for drug-related cognitive/behavioral impairment, monitor for drug related discomfort, discuss progress toward and maintenance of goals for medication therapy, and request medication regimen review. The care plan indicated to refer to psychosocial well-being care plan for non-drug interventions.</p> <p>The Mood and Behavior Symptom</p>			

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	<p>Assessment/Plan of Care for psychosocial well-being - mood status, reviewed 4/16/2015, indicated a problem of the resident being at risk for depression. The goal was for mood and behavior to remain stable and within normal limits daily. The interventions were to continue to monitor mood and behavior daily to promote mental health status, provide reassurance as needed, and discuss progress toward and maintenance of goals for medication therapy.</p> <p>During an interview on 6/26/2015 at 9:00 a.m., Licensed Practical Nurse (LPN)#8 indicated the resident displayed anxiousness by being fearful about everything which included, but not limited to, worrying about her family, medication administration, being on time for her hair appointment, and falling. LPN indicated the resident worried so much that at times she would start to cry. LPN indicated interventions for the resident's behavior were to reorient the resident, reassure the resident she was safe, make sure she went to hair appointment on time, and to check on her frequently as the resident never used her call light. LPN indicated the resident had recently been moved closer to the nurses' station in order to be monitored more closely.</p>			
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	<p>During an interview on 6/26/2015 at 10:00 a.m., Social Service indicated the resident displayed anxiousness by pacing, wringing hands, and displaying inability to process completing simple tasks.</p> <p>The psychotropic medication care plan was not updated to reflect the change in medication dosage and did not identify the specific behavioral symptoms the resident displayed related to anxiousness.</p> <p>The psychosocial well-being care plan problem was not updated to reflect the use of the psychotropic medication or to identify the specific behavioral symptoms associated with the antianxiety medication. The psychosocial well-being care plan goal was not measurable. The psychosocial well-being care plan interventions were not updated to include any non-drug interventions.</p> <p>During an interview on 6/26/2015 at 10:00 a.m., Social Service indicated the psychotropic drug and psychosocial well-being care plans had not been updated.</p> <p>This Federal tag relates to Complaint IN00175631.</p> <p>3.1-35(d)(2)(B)</p>			

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F 0315 SS=D Bldg. 00	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review and interview, the facility failed to ensure there was a clinical indication for use of an indwelling urinary catheter for 1 of 3 residents reviewed for use of indwelling urinary catheter. (Resident #4010)</p> <p>Findings include:</p>	F 0315	<p>F 315 SS - - D</p> <p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;</p> <p>The catheter for Resident #4010 wasdiscontinued per</p>	07/26/2015

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	<p>The clinical record for Resident #4010 was reviewed on 6/25/2015 at 12:15 p.m. Diagnoses included, but were not limited to, morbid obesity, depression, and cellulitis of lower leg.</p> <p>On 6/26/2015 at 12:45 p.m., Resident #4010, was observed with an indwelling urinary catheter.</p> <p>The Bladder Data Collection and Assessment for Resident #4010, dated 5/1/2015, indicated the reason for the indwelling urinary catheter was a Stage 3 or a Stage 4 pressure ulcer. Skin assessment, dated 5/1/2015, indicated Resident #4010 had no pressure ulcers.</p> <p>During an interview on 6/25/2015 at 12:35 p.m., RN #1, indicated the resident had no other skin assessments or wound sheets to indicate that the resident ever had any pressure ulcers. RN#1 indicated the resident had no clinical indication for use of the indwelling urinary catheter and the catheter should have been removed.</p> <p>This Federal tag relates to Complaint IN00175631.</p> <p>3.1-41(a)(2)</p>		<p>physician's order.</p> <ul style="list-style-type: none"> ·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <p>Residents with catheters have the potentialto be affected. Residents with catheters will be reviewed by DNS/designee fordocumentation of appropriate diagnosis to support catheter use. If no diagnosis present, will contact the resident's attending physician for furtherdirection.</p> <ul style="list-style-type: none"> ·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <p>The DNS will provide education to thelicensed nursing staff regarding catheter use. TheInterdisciplinary Team will review residents with pressure wounds who are usingcatheters weekly to evaluate the continued need for the catheter.</p> <ul style="list-style-type: none"> ·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place 		

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F 0356 SS=C Bldg. 00	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p>		<p>The DNS/designee will complete the CatheterAssessment CQI tool weekly x 6, andthen quarterly until continued compliance is maintained for 2 consecutivequarters. The results of the CQI will bereviewed in the monthly CQI meeting overseenby the ED. If the threshold of 100% isnot achieved, an action plan will be developed to assure compliance.</p> <p>bywhat date the systemic changes will be completed. July 26, 2015</p>		

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(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>o Clear and readable format.</p> <p>o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure that nurse staffing information was posted in a prominent place 2 of 2 days of the survey and failed to ensure that nurse staffing information was available for 110 of the past 573 days.</p> <p>Findings include:</p> <p>1. On 6/25/2015 at 9:25 a.m. daily nurse staffing information was observed posted on the east side of the hallway near room 209. The information was not posted in a prominent place readily accessible to residents and visitors. The posting was isolated to one of six hallways. The Automatic External Defibrillator (AED) was on the wall right next to and at the same height as the posted information. The AED limited the visibility of the posted information.</p>	F 0356	<p>F 356 SS-C</p> <p>· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified as affected. The Posted Nurse Staffing Information was relocated to a table in the main lobby The Posted Nurse Staffing Information is now being maintained daily in the Clinical Education Coordinator's office.</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: All residents have the potential to be affected. Education was provided by the DNS/designee to the nursing staff regarding posting the nurse staffing information on or by July 24, 2015</p> <p>· what measures will be put into place or what systemic changes</p>	07/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/26/2015
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	<p>2. The review of staffing data for the past 18 months indicated that data was not available from 6/12/2014 through 8/8/2014 and from 8/10/2014 through 10/1/2014.</p> <p>During an interview on 6/26/2015 at 9:15 a.m., the administrator, indicated that nurse staffing information was not available for 6/12/2014 through 8/8/2014 and from 8/10/2014 through 10/1/2014.</p> <p>This Federal tag relates to Complaint IN00175631.</p>		<p>will be made to ensure that the deficient practice does not recur; Education was provided by the DNS/designee to the nursing staff regarding posting the nurse staffing information on or by July 24, 2015</p> <p>Clinical Education Coordinator/Designee will review the report daily to ensure thereport is accurate</p> <p>Clinical Education Coordinator will keep the staff report for 18 months. DNS will ensure staffing report is kept for 18 months.</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: The ED/designee will complete the Administration CQI tool weekly x4, monthly x 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of the CQI will be reviewed in the monthly CQI meeting overseen by the ED. If the threshold of 100% is not achieved, an action plan will be developed to assure compliance.</p> <p>·by what date the systemic changes will be completed. July 26, 2015</p>		