

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155734	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/08/2014
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NAME OF PROVIDER OR SUPPLIER THORNTON TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 188 THORNTON RD HANOVER, IN 47243
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F000000	<p>This visit was for Recertification and State Licensure Survey. This visit included Investigation of Complaint IN00146512. This visit included a State Residential Licensure Survey.</p> <p>This visit was in conjunction with Investigation of Complaint IN00148397.</p> <p>Complaint IN00146512 - Substantiated. Federal/state deficiencies related to the allegations are cited at F279 and F328.</p> <p>Survey Dates: April 29 and 30, 2014, May 1, 2, 5, 7, and 8, 2014.</p> <p>Facility number: 004075 Provider number: 155734 AIM number: 200491220</p> <p>Survey team: Jennifer Carr, RN, TC Julie Dover, RN Angela Halcomb, RN Brenda Buroker, RN (May 2, 7, and 8, 2014) Janelyn Kulik, RN (May 2, 2014) Rita Bittner, RN (May 5, 7, and 8, 2014) Tammy Forthofer, RN (May 5, 7, and 8, 2014)</p> <p>Census bed type:</p>	F000000	Submission of this plan of correction is not an admission by Thornton Terrace Health Campus that the deficiencies alleged in this survey are accurate or depict the quality of services provided to the residents of this health care facility. This plan of correction is submitted timely in accordance with state and federal regulatory guidelines. This plan of correction is intended to serve as the health facility's credible allegation of compliance with state and federal regulatory requirements.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000272 SS=D	<p>SNF: 17 SNF/NF: 22 Residential: 26 Total: 65</p> <p>Census payor type: Medicare: 20 Medicaid: 12 Other: 33 Total: 65</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on May 16, 2014, by Brenda Meredith, R.N.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;</p>						

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	<p>Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to provide an accurate dental and range of motion assessment using the resident assessment instrument (RAI) specified by the state, for 1 of 4 residents reviewed for oral health status and 1 of 1 resident reviewed for range of motion status (Residents #4 and #40).</p> <p>Findings include:</p> <p>1. During an interview with LPN #4 on 4/30/2014 at 10:16 a.m., she indicated that Resident #40 had contractures (a condition of fixed high resistance to passive stretch of a muscle) of both hands and did not receive range of motion services, nor did she have a splint device</p>	F000272	<p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident #40 was screened by Therapy to determine needs for intervention with contractures. Evaluation and treatment were initiated which included bed mobility, self feeding, and PROM for avoiding risk of further contractures on 5/20/14. The resident profile was updated to reflect current status and plan of care. Resident #40 expired on 5/24/14.</p> <p>Resident #4 had their dental status reassessed by the DON on 5/12/14 and a dental appointment is scheduled for 5/30/14. Resident #4's profile was updated to reflect current status and plan of care. MDS was updated to reflect</p>	06/06/2014

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	<p>in place.</p> <p>Resident #40's clinical record was reviewed on 05/05/2014 at 9:43 a.m. Diagnoses included, but were not limited to, cerebral vascular accident (CVA), history of falls, dementia, arthritis, and osteoporosis.</p> <p>The most recent Minimum Data Set (MDS) assessment for Resident #40, completed on 3/25/2014, indicated that Resident #40 did not receive active (when a person moves a body part on his own without any help or support from the therapist) range of motion. The same assessment also indicated that Resident #40 did not receive passive (when the body part is moved by the therapist without any help from the patient) range of motion. The 12/13/2013 and 3/35/2014 MDS assessments indicated that Resident #40's upper extremities were without impairment.</p> <p>The 9/6/2013 Nursing Admission Assessment & Data Collection indicated Resident #40 had bilateral hand contractures. The 2/16/2014, 3/19/2014, and 4/13/2014 Monthly Nursing Assessments indicated that Resident #40 had bilateral hand contractures and was unable to complete ADLs (activity of daily living) due to both hands being</p>		<p>accurate dental status on 5/30/14.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>All residents were screened by the Occupational Therapist or Physical Therapist on 5/20/14 through 5/28/14. All residents identified through the screening process will be evaluated by a licensed therapist.</p> <p>All residents as well as their medical records were reviewed by DON, ADON, and/or Clinical Nurse team by 5/30/14 for any documented dental issues. MDSs will be reviewed by 6/3/14 for all residents with documented dental issues to verify accuracy of assessments and to make assessment and care plan revisions as indicated.</p> <p>Measures Implemented or Systems Altered to Prevent Reoccurrence:</p> <p>All new admissions will be screened by therapy and/or therapy evaluations will be ordered based on findings. New admissions will be audited by the IDT as part of the 24 hour chart review, and risks for decline in ROM will be identified at this time with appropriate interventions. Any residents with a change in condition that could potentially affect a resident's ROM will be discussed daily 5 days per week in the IDT clinical meeting and referrals to therapy will be made as</p>				

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	<p>contracted.</p> <p>A 12/21/2013 Physician Progress Note indicated, "Patient does complain of hands and loss of function. Resident #40's hands has [sic] multiple contractures, rendering both hands to clubs. Plan is for OT [occupational therapy] to work with pt. [patient] toward goal of flatter hands, and return of useful grasp/grip."</p> <p>The MDS coordinator was interviewed on 5/02/2014 at 2:41 p.m. She indicated, "I interview the staff, and look at the monthly summaries to get my information."</p> <p>The Occupational Therapist was interviewed on 5/5/2014 at 10:32 a.m. She indicated that Resident #40 was referred to therapy on 1/2/2013 due to a decrease in function of her hands. She indicated, "Therapy ordered therapeutic carrots for her to try. She was experiencing pain with any kind of stretching of her hands. The patient was educated on the therapeutic carrots." She further indicated that Resident #40 was discharged from therapy on 1/14/2014 due to progress had ceased. Nursing was informed that the resident was discharged from PT (Physical Therapy) and OT (Occupational Therapy) on 1/14/2014</p>		<p>indicated.</p> <p>On 5/19/14 through 5/22/14 all Nursing staff, including the MDS coordinator, were in serviced by the DON , ADON, and the Therapy Program Director regarding the identification and prevention of decreased ROM and contractures . Nurses will communicate any new findings of residents at risk for decreased ROM or contractures to the therapy department through the Nursing/Therapy Communication form. All completed forms will be reviewed 5 days per week in the IDT clinical meeting.</p> <p>The MDS coordinator was reeducated regarding the assessment process by the MDS administrative support staff on 5/27/14.</p> <p>Any new admission will be reviewed within 24 hours and those with a dental concern will be verified as having an appropriate assessment and interventions as indicated.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>10% of facility census (approximately 6 charts) will be reviewed randomly by the DON or ADON for risk of a decline in ADLS and/or change in dental condition for 12 weeks then every other week for 12 weeks. Random care plan</p>	

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F000279 SS=D	<p>with instructions to continue range of motion exercises and maintain a schedule for therapy carrots.</p> <p>Resident #40 was interviewed on 5/5/2014 at 11:27 a.m. She indicated, "My hands started gradually to turn in, not sure when. If I try to open my fingers, I have pain. For a short time I worked with physical therapy. They gave me therapy carrots to place in my hands. I have not used them lately. I don't know why I am not using them." Resident #40 was asked if she was able to open her hands and was observed to open her right hand slightly and was unable to open her left hand.</p> <p>No care plans related to contractures, range of motion, or therapeutic carrots were identified. Neither the Medication Administration Record (MAR) or Treatment Administration Record (TAR) indicated that the resident was scheduled to, or did receive, range of motion exercises or use of therapeutic carrots.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to</p>		<p>audits will be conducted by the DON and ADON of a minimum of 6 residents for 12 weeks then every other week for 12 weeks. IDT will review care plans during resident care plan meetings and update as needed. Findings of the chart audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine visits.</p>				

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	<p>meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop a comprehensive care plan for a resident who was identified as being at high risk for pressure ulcers and received psychotropic drugs (Resident A) and a resident admitted to the facility for post operative ostomy care and education (Resident B) for 2 of 38 residents reviewed for comprehensive care plans.</p> <p>Findings include:</p> <p>1. The clinical record for Resident A was reviewed on 5/8/14 at 9:15 a.m. and indicated the resident was admitted to the facility in November 2013. The resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, and shortness of breath.</p> <p>The initial Minimum Data Set (MDS) assessment, dated 11/12/13, indicated the</p>	F000279	<p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident #A was discharged to the hospital on 3/9/14.</p> <p>Resident # B was discharged home on 3/19/14.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>There is currently one resident with an ostomy that has the potential to be affected, and the care plan was reviewed and updated on 5/2/14.</p> <p>All residents receiving psychotropic medication have the potential to be affected</p> <p>All residents at risk for pressure ulcer development have the potential to be affected.</p> <p>Measures Implemented or Systems</p>	06/06/2014

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	<p>resident had no pressure ulcers, required extensive assistance for bed mobility, transfer and toileting. The assessment indicated the resident had a foley catheter and was occasionally incontinent of bowel. The assessment indicated the resident scored 10 on the Brief Interview for Mental Status, indicating moderate cognitive impairment. The clinical assessment, dated 11/5/13, indicated the resident was at risk of developing a pressure ulcer. The reason the resident was at risk was that he was noncompliant with turning.</p> <p>The initial MDS assessment indicated the resident exhibited no behaviors or mood problems. The assessment indicated the resident received an antipsychotic drug seven days a week.</p> <p>There was no care plan related to the resident's risk of developing pressure ulcers nor for the use of the psychotropic drug. Interview with the DON on 5/8/14 at 2:21 p.m., indicated that she looked in the care plan and there was nothing regarding the resident's high risk of developing pressure ulcers or the resident's behaviors requiring the use of psychotropic drugs.</p>		<p>Altered to Prevent Reoccurrence:</p> <p>There is currently one resident residing in the facility with an ostomy, and the care plan was reviewed and revised on 5/2/14 to reflect that staff will be performing ostomy care. The care plan and Treatment Administration Record were updated to reflect the orders for colostomy care. The resident's stoma site has been assessed and no impairment has been noted.</p> <p>All nursing staff have been in serviced on the Colostomy and Ileostomy Guidelines by the ADON and/or DON by 5/22/14. Unannounced observations of colostomy care were initiated on 5/19/14. Unannounced random observations of colostomy care will be conducted 3 times a week for 12 weeks then 2 times a week for 12 weeks.</p> <p>All residents were reassessed utilizing the Assessment Review and Considerations form by the DON or ADON to verify that all residents at risk for development of pressure ulcers are properly identified and interventions are care planned with a completion date of 5/9/14.</p> <p>All new admissions will be reviewed within 24 hours to verify that potential risk factors for pressure ulcer development have been properly identified and care planned</p>				

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			<p>accordingly by the DON, ADON or Clinical Nursing team.</p> <p>All residents receiving psychotropic medications were reviewed by the DON and ADON for appropriate diagnosis and care planned appropriately on 5/19/14.</p> <p>The MDS coordinator was in serviced regarding the care planning process by the MDS administrative support staff on 5/27/14.</p> <p>The licensed nursing staff and IDT were in serviced by the DON and ADON from 5/19/14-5/22/14 regarding the development of comprehensive care plans with emphasis on pressure ulcer risks, monitoring of psychotropic medications and ostomy care.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>Any new admission with an ostomy will be reviewed by IDT during the 5 day per week clinical meeting to verify policy and procedure is being followed.</p> <p>All residents identified at risk for developing a pressure ulcer will be reviewed by the IDT in the daily 5 day per week clinical meeting, and</p>	

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			<p>weekly in the Clinically at Risk meeting.</p> <p>All new admissions will be reviewed 5 days a week in the Clinical Care meeting to verify that any resident receiving psychotropic medications are identified as having appropriate diagnoses and are care planned accordingly by the DON, ADON, or the Clinical Nurse team.</p> <p>10% of the facility census (approx 6 charts) will be randomly audited by the DON and or ADON weekly x 12 weeks then every other week x 12 weeks for</p> <p>Findings of the above observations will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine</p>	

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F000314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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 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 record review and interview, the facility failed to provide interventions to prevent the development of pressure ulcers in a resident admitted to the facility without pressure ulcers for 1 of 4 residents reviewed for pressure ulcers. The resident developed an unstageable pressure ulcer within three weeks of being admitted to the facility. (Resident A)</p> <p>Findings include:</p> <p>The clinical record for Resident A was reviewed on 5/8/14 at 9:15 a.m. and indicated the resident had diagnoses of hypertension, diabetes mellitus, and shortness of breath. The resident was admitted to the facility in November 2013. The initial Minimum Data Set (MDS) assessment, dated 11/12/13,</p>	F000314	<p>visits.</p> <p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident #A was discharged to the hospital on 3/9/14.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>All other residents have the potential to be affected .</p> <p>Measures Implemented or Systems Altered to Prevent Reoccurrence:</p> <p>All residents were reassessed utilizing the Assessment Review and Considerations form by the DON or ADON to verify that all residents at risk for development of pressure ulcers are properly identified and interventions are care planned with a completion date of 5/9/14.</p>	06/06/2014

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	<p>indicated the resident had no pressure ulcers, but was at risk for developing pressure ulcers. The MDS assessment indicated the resident needed the extensive assistance of two persons for bed mobility, transfer, dressing and toileting. The resident had a foley catheter and was occasionally incontinent of bowel. There was no plan of care developed to address the resident's risk of developing pressure ulcers.</p> <p>The quarterly MDS assessment, dated 1/17/14, indicated the resident had an unstageable pressure ulcer [slough/eschar; suspected deep tissue injury in evolution] measuring 5 centimeters [cm] long, 3.5 cm wide and 0.3 cm deep.</p> <p>The Treatment Administration Record indicated the resident's skin was assessed weekly and on 11/26/13, the nurse signed that the assessment was completed and a "0" was written on the record to indicate there were no skin issues.</p> <p>A "Pressure/Stasis/Arterial/Diabetic Ulcer Assessment" dated 11/27/13, indicated the resident had an unstageable pressure ulcer on the right hip, measuring 3 cm long by 2.5 cm wide and less than 0.1 cm deep. The assessment indicated the physician and family were notified</p>		<p>All new admissions will be reviewed within 24 hours to verify that potential risk factors for pressure ulcer development have been properly identified and care planned accordingly by the DON, ADON or Clinical Nursing team.</p> <p>All licensed nursing staff were reeducated on the Pressure Prevention Guidelines and Wound Plan of Care Guidelines by the DON and ADON on 5/19/14-5/22/14.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>10% of facility census (approximately 6 residents) will be reviewed randomly by the DON or ADON to verify that potential risk factors have been properly identified and interventions are care planned accordingly. The audit will be completed weekly x 12weeks then every other week for 12 weeks .</p> <p>All residents identified at risk for developing a pressure ulcer will be reviewed by the IDT in the daily 5 day per week clinical meeting, and weekly in the Clinically at Risk meeting. The audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will</p>				

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	<p>and treatment was initiated.</p> <p>The "Skin Impairment Circumstance, Assessment, and Intervention form, completed on 11/27/13, indicated the "res [resident] scoots around in bed & lays predominately on R [right] side. The prevention update was listed as "encourage resident to T & R [turn and reposition] q 2 [every 2 hours]."</p> <p>There was a "Pressure Ulcer Letter of Unavoidability," dated 12/1/13, with two marks indicating the "clinical conditions this resident exhibits that make the likelihood of this pressure ulcer unavoidable include, but are not limited to, resident immobility and: Pale skin and Noncompliance with care interventions, Turning and positioning." "Res only likes to lay on R [right] side."</p> <p>The resident's laboratory results, dated 11/3/13 indicated: Albumin 3.8 (3.7 - 4.8) Total Protein 6.6 (6.7 - 8.9)</p> <p>There was no plan of care to address the resident's desire to lay on his left side, nor that he was noncompliant with turning from admission until the wound was identified on 11/27/13.</p> <p>The DON (Director of Nursing) was</p>		<p>be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine visits.</p>	

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	<p>unable to provide a policy and procedure regarding interventions for a resident identified as being at high risk for pressure ulcers when requested on 5/8/14 at 11:14 a.m.</p> <p>Interview with the DON on 5/8/14 at 2:21 p.m., indicated the resident was big in size and he liked to stay up in the wheel chair and not lie down. She was unable to explain why the resident was assessed on 11/26/13 as having no skin concerns and on 11/27/13 was found with an unstageable pressure ulcer. She was unable to find a plan of care to address the resident's high risk for developing pressure ulcers. There was no plan to educate the resident on the risks associated with not following a turning schedule.</p> <p>The resident developed a second pressure ulcer on the left hip. It was first noted on 12/31/13 as a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough.), measuring 7 cm long, 8 cm wide and 0.2 cm deep.</p> <p>The resident continued to have the wounds when discharged from the facility in March 2014. The right hip wound was a Stage 4 (full thickness of</p>			

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F000318 SS=G	<p>skin and subcutaneous tissue is lost exposing the muscle and/or bone) and measured 2 cm long, 2.4 cm wide and 1 cm deep. The left hip wound was assessed as a Stage 2, measuring 1 cm long, 1 cm wide and 1.5 cm deep.</p> <p>3.1-40(a)(1) 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, interview and record review, the facility failed to ensure appropriate treatment to prevent a further decrease in range of motion for 1 of 1 resident reviewed for range of motion (Resident #40). This deficient practice resulted in harm in that Resident #40, who's upper extremities were without impairment when she was admitted to the facility, developed bilateral hand contractures and is unable to complete activities of daily living (ADLs) as a result.</p> <p>Findings include:</p> <p>During staff interview with LPN #4 on 4/30/2014 at 10:16 a.m., she indicated that Resident #40 has contracture</p>	F000318	<p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident #40 expired 5/24/14. Occupational therapy evaluated Resident #40 and was treating 3 times a week for 4 weeks for bed mobility, self feeding, and PROM for avoiding risk of further contractures on 5/20/14. Physical therapy evaluated resident #40 for treatment 3 times a week for 4 weeks to avoid risk of shortened muscle of bilateral lower extremities by performing passive range of motion and active- assisted range of motion.</p> <p>How other Residents were Identified in the Deficiency:</p>	06/06/2014

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	<p>(defined as a condition of fixed high resistance to passive stretch of a muscle) of both hands and does not receive range of motion services nor does she have a splint device in place.</p> <p>Resident #40's clinical record was reviewed on 05/05/2014 9:43 a.m. Diagnoses included, but were not limited to, cerebral vascular accident (CVA), falls, dementia, arthritis, osteoporosis.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 12/31/2013, indicated Resident #40 was a one person physical assist for Bed Mobility, Transfers and Toilet use. For eating, Resident #40 required set up assistance.</p> <p>The annual Minimum Data Set assessment dated 3/25/2014, indicated Resident #40 was required two or more people to physical assist for Bed Mobility, Transfers and Toilet use. For eating, Resident #40 required one person to physically assist.</p> <p>The most recent Minimum Data Set assessment, completed on 3/25/2014, indicated that Resident #40 did not receive active (when a person moves a body part on his own without any help or support from the therapist) range of motion. This assessment also indicated</p>		<p>All residents have potential to be at risk for decrease in range of motion or contractures and were screened by the Occupational Therapist or Physical Therapist on 5/20/14 through 5/28/14 . All residents identified through the screening process will be evaluated by a licensed therapist.</p> <p>Measures Implemented or Systems Altered to Prevent Reoccurrence:</p> <p>All new admissions will be screened by therapy and/or evaluations ordered based on findings. New admissions will be audited by the IDT as part of the 24 hour chart review and risks for decline in ROM will be identified at this time and interventions put in place. Any residents with change in condition that could potentially affect a resident's ROM will be discussed daily 5 days per week in the IDT clinical meeting and referrals to therapy will be made as indicated.</p> <p>Beginning 5/19/14 and through 5/22/14 all Nursing staff, including the MDS coordinator, were in serviced by the DON , ADON, and Therapy Program Director regarding identification and prevention of decreased ROM or contractures . Nurses will communicate any new findings of residents at risk for decreased ROM or contractures to the therapy department through the Nursing/Therapy</p>				

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	<p>that Resident #40 did not receive passive (when the body part is moved by the therapist without any help from the patient) range of motion. The MDS, indicated that on 12/31/2013, and 3/35/2014, Resident #40's upper extremities were without impairment. The Resident #40's Brief Interview for Mental Status (BIMS) score was 13 of 15, indicating that she was cognitively intact.</p> <p>A Nursing Admission Assessment & Data Collection, dated 9/6/2013, indicated Resident #40 had bilateral hand contractures.</p> <p>The Monthly Nursing Assessments, dated 2/16/14, 3/19/14 and 4/13/2014, indicated Resident #40 had bilateral hand contractures and was unable to do ADLs (activities of daily living) due to both hands being contracted.</p> <p>A 12/21/2013 Physician Progress Note indicated, "Patient does complain of hands and loss of function. Resident #40's hands has [sic] multiple contractures, rendering both hands to clubs. Plan is for occupational therapy (OT) to work with pt. [patient] toward goal of flatter hands, and return of useful grasp/grip."</p>		<p>Communication tool. Any referrals will be reviewed in the daily 5 day per week IDT clinical meeting.</p> <p>The MDS coordinator was reeducated regarding the assessment process by the MDS administrative support staff on 5/27/14.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>10% of facility census (approximately 6 charts) will be reviewed randomly by the ADON or DON for risk of a decline in ADLs and for proper care planning weekly x 12 weeks, then every other week x 12 weeks. IDT will review care plans during resident care conferences and update as needed. The audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for</p>		

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	<p>The Occupational Therapist was interviewed on 5/5/2014 at 10:32 a.m., She indicated that Resident #40 was referred to therapy on 1/2/2014, due to a decrease function of hands. She indicated that "Therapy ordered therapeutic carrots for her to try, she was experiencing pain with any kind of stretching of her hands, the pt [patient] was educated on the therapeutic carrots." Resident #40 was discharged from therapy on 1/14/2014 due to progress had ceased. Nursing was informed that the pt. was discharged from PT (Physical Therapy) and OT (Occupational Therapy) on 1/14/2014, and to continue ROM (range of motion) and maintain schedule for therapy carrots.</p> <p>Resident #40 was interview on 5/5/2014 at 11:27 a.m. She indicated my hands started gradually to turn in, not sure when. If I try to open my fingers I have pain. For a short time I worked with physical therapy. They gave me therapy carrots to place in my hands, I have not used them lately." I don't know why I am not using them." When Resident #40 was ask, if she was able to open her hands, Resident #40 was observed to open right hand slightly and unable to open left hand.</p> <p>There were no care plans related to</p>		non-compliance. Home Office Support follows up on these action plans for corrections during routine visits.				

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F000328 SS=G	<p>contractures, range of motion, or therapeutic carrots identified. Neither the Medication Administration Record (MAR) or Treatment Administration Record (TAR) indicated that the resident was scheduled to, or did receive, range of motion exercises or use of therapeutic carrots.</p> <p>3.1-42(a)(2) 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview, and record review, the facility failed to provide proper treatment and care for 3 residents receiving ostomy care for 3 of 3 residents reviewed for special services related to ostomy care (Residents B,C, and D). This deficient practice resulted in harm in that 1 resident's (Resident B) skin became impaired as a result of improper treatment and care of his ileostomy site.</p> <p>Findings include:</p>	F000328	<p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident # B was discharged home on 3/19/14.</p> <p>Resident #C expired on 5/26/14.</p> <p>Resident #D's care plan was reviewed and revised on 5/2/14 to reflect that licensed staff will be performing ostomy care. The care plan and Treatment Administration Record were updated to reflect the orders for colostomy care. This is</p>	06/06/2014

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	<p>1. Resident B's closed clinical record was reviewed on 5/8/2014 at 10:29 a.m. and indicated that Resident B was admitted to the facility on 3/13/2014 following an exploratory laparotomy, small bowel obstruction, and ileostomy (surgical construction of an artificial excretory opening through the abdominal wall) placement for post-surgical rehabilitation and education. Diagnoses included, but were not limited to, small bowel obstruction, amastomasis (leaking), malaise, history of lung resection, and ileostomy. Resident B was discharged from the facility on 3/19/14.</p> <p>A 3/13/2014 Nurse's Note indicated, "Had recent surgery for CA [cancer]. Now has ileostomy with ABD [abdominal] incision [down arrow] ostomy. Incision with drsg [dressing]. Proxy. [approximately] 7" [inch] length incision with sutures present. To see Dr. [name] on 3/19/2014 for suture removal."</p> <p>Physician's Orders dated 3/13/14 indicated, "...Dry sterile drsg [dressing] to wound daily and prn [as needed]. Ostomy care prn [as needed] enc [encourage] resident to do."</p> <p>Plan of Care, dated 3/13/2014, indicated, "Problem: ABD [abdominal] Incision.</p>		<p>the only resident that remains in the campus with an ostomy. Resident #D's stoma site has been assessed and no impairment has been noted.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>There are no other residents that have ostomies.</p> <p>Measures Implemented or Systems Altered to Prevent Reoccurrence:</p> <p>All nursing staff have been in serviced on the Colostomy and ileostomy guidelines by the ADON and/or DON by 5/22/14. Unannounced observations of colostomy care being conducted were initiated on 5/19/14. Unannounced random observations of colostomy care will be conducted 3 times a week for 12 weeks and then 2 times a week for 12 weeks.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>Results of observations will be reviewed by the IDT in the daily 5 day per week clinical meeting, and weekly in the Clinically at Risk meeting. The audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved.</p>	

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	<p>Goal: To have no s/s [signs/symptoms] infection. Intervention: Change drsg [dressing] daily per order. Observe for s/s infection. Empty, [change symbol] ileostomy bag as needed. There were no additional care plans related to ileostomy care or resident education.</p> <p>A review of the Medication Administration Records for 3/13/2013-3/31/2013, indicated, "Ostomy care prn [as needed]. Enc [encourage] Resident to do." There was no documentation that this was done at any time.</p> <p>The 3/13/2014 Nursing Admission Assessment and Data Collection indicated "ileostomy" under the section entitled, "Elimination." There was nothing related to Resident B's ileostomy indicated under the section entitled, "Elimination Plan of Care."</p> <p>Skilled Nursing Assessment and Data Collection Forms, dated 3/15/2014 through 3/18/2014, indicated only "surgical wound" under the section entitled, "Skin".</p> <p>No additional Nurse's Notes, Physician Progress Notes, Care Plans, or other records were identified which documented any assessment of the stoma</p>		<p>If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine visits.</p>				

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	<p>or care provided.</p> <p>During an interview with LPN #4 on 5/2/2014 at 10:45 a.m., she indicated that staff does not document who provided colostomy care, when it was provided, a description of the stoma/site, or what type/size of wafer,bag, or supplies were used.</p> <p>During a phone interview with Resident B's daughter on 5/8/2014 at 11:23 a.m., she indicated that her father was left to lay in his colostomy leakage for several hours at a time and had "pretty bad burns" on the skin surrounding his ileostomy stoma. She further indicated that when the resident was seen for a follow-up appointment on 3/19/2014, the physician and nurse indicated to her that the burns were caused by leakage (of gastro-intestinal contents) around the site as a result of staff "cutting the hole too big". She further indicated, "They were having a hard time getting the bags to stay on because of the burns. They were supposed to be good for 3 days or so, but they were having to change them twice a day or so. They did finally order a special powder...'stoma powder' I think....It took several weeks to recover with the home health nurse." Resident B's daughter also indicated that Resident B was not independent with his</p>						

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	<p>colostomy care and was dependent on staff to change and empty the bag. She indicated that when he was discharged to home with home health services on 3/19/2014, he did not know how to care for his ileostomy site.</p> <p>During an interview with the Home Health Nurse who cared for Resident B following his discharge from the facility on 3/19/2014, she indicated that the resident had an "excoriated" area surrounding his stoma site, which took approximately one week to heal following his discharge. She further indicated that the resident did not receive adequate education and that the resident was not discharged with any ileostomy supplies, which is common practice.</p> <p>During an interview with the Director of Nursing (DoN) on 5/8/2014 at 2:47 p.m., she indicated that they do provide resident teaching related to self-care of ileostomy/colostomy sites and that it is normally included in the care plan. She indicated, "I don't recall any excoriation around the stoma...rings being cut wrong...or leakage. The nurses would normally report something like that to me and then there would be a skin sheet." She further indicated, "We would send home 72 hours worth of supplies with instructions on how they can get</p>			

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	<p>supplies." She indicated that she could not find any documentation in Resident B's record that supplies were sent home with him when he was discharged on 3/19/2014. Additionally, she indicated that she could not find any Nurse's Notes, Physician Progress Notes, Care Plans, or other records which documented any assessments of the stoma or surrounding skin, how often care was provided, or any other documentation related to Resident B's ileostomy care.</p> <p>2. Resident D's clinical record was reviewed on 5/2/2014 at 10:10 a.m. Diagnoses included, but were not limited to, dementia, recent subdural hematoma, and partial colectomy with colostomy secondary to diverticulitis.</p> <p>The most recent Minimum Data Set (MDS) assessment, dated 3/19/2014, indicated that Resident D had a Brief Interview for Mental Status (BIMS) score of 13; which indicated that she was cognitively intact.</p> <p>Resident D was interviewed on 5/2/2014 at 10:28 a.m. regarding her colostomy care. She indicated, "Yes, they [staff] have problems. I don't know how to answer it cuz [sic]...we have some trouble sometimes...my, my, my...do they have all the supplies they need? Not</p>			

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	<p>always."</p> <p>Recapitulated Physician's Orders for April, 2014 and May, 2014 indicated, "Colostomy care every shift - independent with care."</p> <p>Nurses Notes dated 4/15/2014 indicated, "Req [requires] assist with ADLs [activities of daily living]. Does have periods of confusion. Res [resident] does own colostomy care...."</p> <p>The 4/17/2014 Monthly Nursing Assessment & Data Collection indicated, "Requires assist with all ADLs due to weakness and being unsteady when up. Res is non-ambulatory....Res has colostomy and does own care."</p> <p>During an interview with LPN #4 on 5/2/2014 at 10:35 a.m., she was queried regarding orders and/or policy and procedure for Resident D's colostomy care. She indicated, "There's no real order. She's pretty independent with it. She lets us know when it needs to be changed."</p> <p>Resident D's call light sounded on 5/2/2014 at 10:37 a.m., and LPN #4 responded. She indicated, "It [colostomy bag] came undone...maybe when she turned or something." A large amount of</p>			

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	<p>brown liquid was observed to have leaked around the stoma site. LPN #4 was observed to gather supplies, don gloves, and pull the soiled wafer/bag from Resident D's skin. She cleaned the site with water and attempted to place the new, clean wafer over the stoma. The opening was noted to be several centimeters too small. She indicated, "Let me get my scissors." She then removed her gloves and washed her hands for 9 seconds before donning new gloves. LPN #4 removed scissors from her uniform and cut a jagged, uneven hole slightly larger than the original opening. She was observed to place the wafer on the stoma, with 1/3 of the wafer sitting on top of the stoma and not flush with the skin around the stoma. She then attached the colostomy bag. She removed her gloves and washed her hands for 5 seconds before exiting the room.</p> <p>During an interview with LPN #4 on 5/2/2014 at 10:45 a.m., she indicated that staff does not document when they change the bag or wafer or provide colostomy care. She indicated, "It's just included in the 'Colostomy care Q shift. Independent with care.' order on the MAR." When asked how she would know when the bag was changed last, she indicated, "I could put it on the report</p>						

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	<p>sheet. I probably will put it on the report sheet, but I can't say everyone does."</p> <p>Regarding documentation that Resident D is "independent with colostomy care", LPN #4 indicated, "At times she is....sometimes she'll empty her own bag into the toilet." She further indicated that Resident D does not change her own bag or wafer or provide stoma care.</p> <p>During an interview with the Director of Nursing (DoN) on 5/2/14 at 2:16 p.m., she indicated, "The doctor wanted the order written that way because it's the one thing she has to hang on to...for her independence." She further indicated that staff do not receive additional training related to colostomy/ileostomy care.</p> <p>On 5/2/2014 at 2:27 p.m., the DoN was asked to observe Resident D's colostomy site subsequent to the colostomy care provided at 10:37 a.m. Upon entering the room, Resident D was found sitting in her wheelchair with a brown substance on her shirt and a large amount of brown liquid which had leaked through her adult brief and was leaking out around the wafer adhesive. The DoN donned gloves prior to assessing the resident's colostomy site. She then removed the gloves and was observed to wash her hands for 3 seconds before donning clean</p>			

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F000329 SS=D	<p>gloves. She and RN #3 assisted Resident D to the bathroom via wheelchair and the DoN was observed to wipe a large amount of brown liquid from the seat of Resident D's wheelchair up towards the front of Resident D's peri-area. RN #3 cut a new wafer with scissors, donned gloves, placed the new wafer and bag onto Resident D's stoma, removed her gloves, and left the room. She did not wash her hands at any time.</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview,</p>	F000329		06/06/2014			

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	<p>the facility failed to provide adequate monitoring for 1 resident receiving the anti-coagulant medication coumadin (Resident #37) and rationale or diagnosis for 1 resident receiving antipsychotic medication with no documentation of behaviors (Resident #76), for 1 of 6 residents reviewed for unnecessary drugs.</p> <p>Findings include:</p> <p>1. Resident #37's record was reviewed on 5/5/2014 at 10:32am. She was admitted to the facility on 4/18/14. Diagnoses included, but were not limited to, history of CVA (cerebral vascular accident/stroke), dementia, hypertension, and atrial fibrillation (AFib).</p> <p>Physician's Orders, from re-admission date of 4/18/14 through 4/30/2014, indicated, "Coumadin 3mg per G-tube at HS 1900 [7:00 p.m.]. Dx: A Fib". Physician's Orders for May, 2014 indicated, "Coumadin 3mg tab x 1 daily per GT [G-tube] for AFib [atrial fibrillation] PT/INR [blood test to determine therapeutic effects of coumadin medication] due _____ [blank]. Notify MD of PT/INR results before giving coumadin."</p> <p>The April, 2014 Medical Administration Record (MAR) indicated that the</p>		<p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>The physician was notified on 5/5/14 to obtain an order for a PT INR for resident #37. An order was received to draw a PT INR on 5/5/14 . Lab was drawn on 5/5/14, and results were normal. An order was obtained to repeat PT INR in one month. Resident was assessed by a licensed nurse and had no signs/symptoms of bleeding on 5/5/14 . The care plan was updated to reflect new orders.</p> <p>Resident #76 was discharged to the hospital on 3/9/14.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>All residents on Coumadin were reviewed and verified that each has an order for appropriate lab monitoring (PT INR) by the DON or ADON on 5/7/14. Each care plan was reviewed to reflect lab monitoring by the DON or ADON . All licensed nursing staff were reeducated by the DON and/or ADON on the facility's procedural guidelines for Coumadin monitoring which was completed on 5/22/14.</p> <p>All residents receiving psychoactive medications have the potential to be affected by the practice</p> <p>Measures Implemented or Systems</p>				

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	<p>medication was administered to Resident #37 as ordered 4/19/14 through 4/30/2014. A review of Resident #37 laboratory results indicated that no PT/INR was performed from the time the coumadin was ordered on 4/18/2014 through the record review date of 5/5/2014.</p> <p>During an interview with the Director of Nursing (DoN) on 5/7/2014 at 12:03 p.m., she indicated that Resident # 37 was administered coumadin as ordered from 4/19/2014 through 5/5/2014 without receiving a PT/INR. She provided a Physician's Telephone Order, dated 5/5/2014, which indicated, "Obtain PT/INR today. Dx [diagnosis]: coumadin therapy / hx [history] CVA [cerebral vascular accident/stroke]." She also provided a copy of a Resident Coag Testing Record, dated 5/5/2014, which indicated the results of the PT/INR performed on 5/5/2014 at 11:30 a.m., with "O.K." and the physician's signature written across the middle of the page.</p>		<p>Altered to Prevent Reoccurrence:</p> <p>All new admissions will be reviewed within 24 hours to verify that any resident receiving Coumadin has appropriate lab monitoring in place and are care planned accordingly by the DON, ADON, and/or Clinical Nursing team. All new orders will be reviewed 5 times a week in the IDT clinical meeting.</p> <p>All new admissions will be reviewed 5 days a week in the Clinical Care meeting to verify that any resident receiving psychotropic medications have appropriate diagnoses. Residents will be properly identified and care planned accordingly by the DON, ADON, or the Clinical Nurse team.</p> <p>All nursing staff and Social Services were reeducated on the Psychotropic Medication Usage, Behavior monitoring, and Gradual Dose Reductions by the DON and/or ADON which was completed on 5/22/14.</p> <p>All residents receiving psychoactive medications were reviewed to verify appropriate diagnosis and care planned accordingly. This was completed on 5/22/14 by the DON.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p>		

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			<p>10% of facility census (approximately 6 residents) receiving Coumadin will be reviewed randomly by the DON or ADON to verify appropriate lab monitoring is in place and is care planned accordingly. The audit will be completed weekly x 12 weeks then every other week for 12 weeks.</p> <p>10% of facility census (approximately 6 residents) receiving psychotropics will be reviewed randomly by the DON or ADON, and/or Clinical Nursing Team to verify appropriate diagnosis, behavior monitoring, and is care planned accordingly. The audit will be completed daily for 12 weeks then every other week for 12 weeks.</p> <p>The audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office</p>	

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F000371 SS=F	<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 the facility failed to provide a sanitary space for food preparation. This deficient practice had the potential to impact 39 of 39 sampled residents.</p> <p>Findings include:</p> <p>During an observation on 5/2/2014 at 11:11 a.m., the dietary manager had latex gloves on outside of kitchen area. He entered the kitchen and removed the glove from his left hand and washed both hands at the hand washing sink. While keeping the same glove on his right hand he checked the temperatures of the food on the steam table.</p> <p>During a kitchen observation on 5/5/2014 at 11:15 a.m., an opened jar of peanut butter was on the preparation counter. The hand washing sink was 11 and 1/2 inches away from the preparation</p>	F000371	<p>Support follows up on these action plans for corrections during routine visits.</p> <p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>The Dietary Manager as well as all dietary staff were in serviced on 5/22/14 for proper donning and doffing of gloves, hand washing, and maintaining infection control measures while at the preparation area. The entire dietary staff including cook #1 were educated on infection control procedures at the serving station.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>All residents have the potential to be affected.</p> <p>Measures Implemented or Systems Altered to Prevent Reoccurrence:</p> <p>A splash guard was installed between the hand washing sink and the prep counter on 5/29/14.</p>	06/06/2014

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	<p>counter. When hands were washed, the water and soap had the potential to splatter the peanut butter.</p> <p>On 5/2/2014 at 11:16 a.m., the dietary manager was observed leaning against the preparation counter. A large portion of his buttocks was resting on the surface of the preparation counter. This counter contained a slice of tomato, lettuce, bread, and the jar of peanut butter.</p> <p>During the kitchen observation on 5/2/2014 at 11:18 a.m., the daily menus for the residents were on the serving line counter next to a stack of clean napkins. The menus were knocked off onto the floor by cook #1 and she picked the menus up off the floor and placed them back on the serving line counter next to the clean napkins.</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>		<p>The Dietary Manager as well as all dietary staff were in serviced on 5/22/14 for proper donning and doffing of gloves, hand washing, and maintaining infection control measures while at the preparation area. The entire dietary staff including cook #1 were educated on infection control procedures at the serving station.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>Unannounced audits of the kitchen will be conducted by the administrator 4 days per week for 4 weeks, 2 days per week for 4 weeks, and then once a month for 2 months. Audits will be conducted to ensure that proper infection control is maintained in the dietary department</p> <p>The audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This</p>	

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F000441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by</p>		<p>review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine visits.</p>	

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	<p>accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice for 2 of 10 observations of handwashing.</p> <p>Findings include:</p> <p>1. LPN #4 was observed providing colostomy care to Resident D on 5/2/2014 at 10:37 a.m. LPN #4 entered the room, gathered supplies, and donned clean gloves. She removed the soiled wafer/bag from Resident D's skin, cleaned the site with water, and then attempted to place the new, clean wafer over the stoma. She indicated, "Let me get my scissors." She then removed her gloves and washed her hands for 9 seconds before donning new gloves. LPN #4 removed scissors from her uniform and continued with the procedure. She removed her gloves and washed her hands for 5 seconds before exiting the room.</p> <p>2. The Director of Nursing (DoN) and</p>	F000441	<p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident # D was assessed by a licensed nurse on 5/3/14 and showed no signs or symptoms of infection.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>All residents have the potential to be affected .</p> <p>Measures Implemented or Systems Altered to Prevent Reoccurrence:</p> <p>LPN #4, RN #3, and DON were reeducated on Infection control with emphasis on proper hand washing by the Administrative support staff on 5/28/14. All nursing staff were reeducated on the infection control policy with emphasis on hand washing by the ADON completed on 5/22/14.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>Unannounced observations will be conducted by the ADON to verify proper hand washing is being</p>	06/06/2014

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	<p>RN #3 were observed to provide colostomy care and peri-care to Resident D on 5/2/2014 at 2:16 p.m. Upon entering the room, Resident D was found sitting in her wheelchair with a brown substance on her shirt at the level of her colostomy and a large amount of brown liquid which had leaked through her adult pull up and was leaking out around the wafer adhesive. The DoN donned gloves prior to assessing the resident's colostomy site. She then removed the gloves and washed her hands for 3 seconds before donning clean gloves. She and RN #3 assisted Resident D to the bathroom via wheelchair and the DoN was observed to wipe a large amount of brown liquid from the seat of Resident D's wheelchair, near her rectum, up towards the front of Resident D's peri-area. RN #3 cut a new wafer with scissors, donned gloves, placed the new wafer and bag onto Resident D's stoma, removed her gloves, and left the room. She did not wash her hands at any time.</p> <p>Guidelines for Handwashing was provided by the DoN on 5/8/2014 at 10:35 a.m. and reviewed at that time. The policy included, but was not limited to, "Handwashing is the single most important factor in preventing transmission of infections....All health care workers shall wash their hands</p>		<p>performed by the nursing staff. These audits will be of 3 different staff members daily for one week, then 3 times a week for 4 weeks, then weekly for 2 months.</p> <p>The audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine visits.</p>				

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R000000	<p>frequently and appropriately....Health Care Workers shall wash hands at times such as:...Before/after having direct physical contact with residents. After removing gloves, worn per Standard Precautions for direct contact with excretions or secretions, mucous membranes, specimens, resident equipment, grossly soiled linen, etc....Turn water on to a comfortable temperature. Wet hands with running water....Wash well for 20 seconds...."</p> <p>3.1-18(l)</p> <p>This deficiency reflects a state finding cited in accordance with 410 IAC 16.2-5.</p>	R000000	Submission of this plan of correction is not an admission by Thornton Terrace Health Campus	

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R000051	<p>410 IAC 16.2-5-1.2(u) Residents' Rights - Offense (u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms.</p> <p>Based on observation, record review and interview the facility failed to ensure resident's were free of chemical restraints for 1 of 5 residents reviewed related to the use of an antipsychotic medication (medication used to treat schizophrenia) for convenience and not used for treating a resident's medical symptoms. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1 was observed on 5/2/14 at 10:05 a.m. sitting in a chair with her back to the door. She was having her hair curled.</p> <p>Resident #1 was observed on 5/2/14 at</p>	R000051	<p>that the deficiencies alleged in this survey are accurate or depict the quality of services provided to the residents of this health care facility. This plan of correction is submitted timely in accordance with state and federal regulatory guidelines. This plan of correction is intended to serve as the health facility's credible allegation of compliance with state and federal regulatory requirements.</p> <p>Corrective Measures for Resident(s) Identified in the Deficiency:</p> <p>Resident #1's physician clarification order was obtained on 5/13/14, and a care plan was initiated for the diagnosis of dementia with delusions.</p> <p>How other Residents were Identified in the Deficiency:</p> <p>All residents receiving psychotropic medication have the potential to be affected. All residents receiving psychotropic medications were reviewed by the DON and ADON for appropriate diagnosis on 5/17/14.</p> <p>Measures Implemented or Systems</p>	06/06/2014

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	<p>1:05 p.m. The resident was walking down the hall with her family.</p> <p>The resident's record was reviewed on 5/2/14 at 12:00 p.m. Her diagnoses included, but were not limited to, psychosis, senile dementia with delusions, hypertension, osteoporosis, hypothyroidism, and hyperlipidemia.</p> <p>A Nurse's Note dated 1/4/14 at 2:00 p.m. indicated, resident had wandered into another resident's room three times. She had moved a chair and turned on a light. The resident was redirected to her own room and would not stay in her room. At 10:00 p.m. the resident was wandering into other resident's rooms. The resident was assisted to her room and into bed.</p> <p>A Nurse's Note dated 4/3/14 at 8:45 p.m. indicated, the resident was wandering in and out of other resident's rooms. She was easily redirected but continued to try to go in other resident's rooms. She complained of leg and was medicated. The staff were to monitor for wandering.</p> <p>A Nurse's Note dated 4/5/14 at 6:00 p.m. indicated, there resident wondered into another resident's room, she was redirected then went into a different resident's room and used their bathroom before staff could redirect her. Resident</p>		<p>Altered to Prevent Reoccurrence:</p> <p>All licensed nursing staff and the Social Service Director were in serviced from 5/19/14 through 5/22/14 by the DON and ADON . All new admissions will be reviewed daily 5 days per week in the clinical meeting for 12 weeks, and every other week for 12 weeks by the DON, ADON, Social Service Director and/or Clinical Nursing Team to verify appropriate diagnosis for all psychoactive medications.</p> <p>Monitoring Measures to Maintain Ongoing Compliance:</p> <p>Findings of the chart audits will be presented in the QA meeting for review and any further recommendations if indicated until substantial compliance is achieved. If concerns are identified, reeducation and or counseling will be provided. In addition, monitoring will take place during monthly QA meetings which will require action plan development for non-compliance and through the Home Office Peer Review process. The Peer Review process is conducted twice a year with an IDT from other Trilogy facilities. This review evaluates systems implementation and requires action plans be developed for non-compliance. Home Office Support follows up on these action plans for corrections during routine</p>		

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	<p>#1 was redirected.</p> <p>A Nurse's Note dated 4./10/14 at 2:00 p.m. indicated, spoke to daughter concerning resident's wandering in other resident's rooms. The wandering happens more during early evening and bedtime. Staff discussed with the daughter about giving pain medication at bedtime to help the resident relax. It was explained that with residents with dementia they do not always recognize pain. The resident would occasionally state she was in pain. The daughter indicated Physician #1 had said the same thing. The daughter was agreeable to try pain medication at bedtime to see if it helped. The daughter also stated she had an appointment the 1st of May to see Physician #1 and she would ask if there might be something else he could give the resident for the wandering.</p> <p>A Social Progress Note dated 4/11/14 at 1600 (4:00 p.m.) indicated, the resident had been wandering into others room. She had an appointment being scheduled and a toileting plan put into place. Staff would continue to observe and redirect resident.</p> <p>A Social Progress Note dated 4/17/14 at 10:45 a.m. indicated, the Ombudsman was notified of the resident's wandering</p>		visits.				

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	<p>into others room and other resident's family concerns. The Ombudsman was notified of toileting plan and physician appointment and that staff were observing and redirecting the resident as needed.</p> <p>A physician order dated 4/18/14 indicated, Risperdal (anti-psychotic medication used to treat schizophrenia) 0.25 mg, by mouth at bedtime for the diagnosis of anxiety.</p> <p>A Change In Condition Form dated 4/18/14 indicated, family requested anti-anxiety mediation for resident to help calm at bedtime. The physician ordered Risperdal 0.25 mg, one by mouth at bedtime.</p> <p>A Patient Message (note from Physician #1's office) provided by the Director of Nursing on 5/2/14 at 2:45 p.m. indicated, on 4/14/14 at 10:14 a.m. patient's daughter called and stated that the facility her mother was at called and stated that she was wandering in patient's rooms in the evening. She was wondering if Resident #1 could be started back on Risperidone 0.25 mg at bedtime. The Physician indicated to try. The information was sent to the pharmacy and the resident's daughter was aware.</p>			

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	<p>A professional resource, titled, "Nursing 2014 Drug Handbook", Page 1214 indicated Risperidone was indicated for schizophrenia. The source further indicated nursing consideration, "Fatal CV or infectious adverse events may occur in elderly patients with dementia. Drug isn't safe or effective in these patients."</p> <p>Interview with RA#1 on 5/2/14 at 1:10 p.m. indicated, the resident had been wandering into other residents rooms and using their bathroom. She indicated she thought the resident had been started on medication. She further indicated it seemed to have worked.</p> <p>Interview with the Director of Nursing on 5/2/14 at 1:45 p.m. indicated Resident #1 had been wandering. Staff had redirected the resident and started her on a toileting program. She indicated there was no documentation of the toileting program. She would have to look at the record to see if anything else was done for the resident. She obtained the resident's record and indicated they tried pain medication before bedtime. The Administrator joined the interview and indicated a family member had complained twice about Resident #1 wandering into his family member's room. The family member was going to</p>			

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	<p>speak to Resident #1"s family. The Administrator asked the family member to not do this and the facility would handle the concern. The Director of Nursing further indicated she was not sure why the resident was started on the Risperdal. She thought the family had taken the resident to see the physician. The Director of Nursing indicated she had not been seen by Psychiatric Services in the facility.</p>			