

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155120	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/25/2016
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00197809.</p> <p>This visit was in conjunction with Complaint IN00200645.</p> <p>Complaint IN00197809-Substantiated. Federal/State deficiencies related to the allegations are cited at F244, F246, and F315.</p> <p>Survey dates: May 17, 18, 19, 20, 23, 24, and 25, 2016</p> <p>Facility number: 000050 Provider number: 155120 AIM number: 100266170</p> <p>Census bed type: SNF/NF: 109 Total: 109</p> <p>Census payor type: Medicare: 4 Medicaid: 78 Other: 27 Total: 109</p> <p>These deficiencies reflect State findings</p>	F 0000		

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 0223 SS=D Bldg. 00	<p>cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on June 7, 2016</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure one resident was not physically abused. This affected 1 of 3 residents reviewed for abuse. (Resident #101)</p> <p>Findings include:</p> <p>During an interview, on 5/19/16 at 2:21 p.m., the Alzheimer's Care Coordinator indicated: "I was in the nursing station on the phone with the [Director of Nursing] (DoN) and I saw [CNA #14]</p>	F 0223	<p>Res 101 A head to toe skin assessment was completed by a licensed nurse on Resident 101 and no injuries were noted. Resident 101 was monitored for any behavioral changes with none noted. CNA #14 was terminated. Res Identified CNA#14 suspended immediately following allegation and terminated at completion of investigation Others All residents had the risk to potentially be affected by this deficient practice. CNA #14 was terminated. The facility will continue to train on resident abuse during new employee</p>	06/24/2016			

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	<p>shove [Resident #101]. The resident started to lose her balance and she self corrected but she did not fall, so I reported to the [DoN] while I was the phone with her. I called and told [Unit Coordinator #6]. [CNA #14] then pushed another resident in a wheelchair past [Resident #101]. [The] DoN and me, immediately within 5 minutes, had her clock out and leave the facility, the CNA [#14] did not say anything she just said "ok". Never witnessed abuse with [CNA #14] before with residents but [she] has a poor attitude, refuses inservices, bangs things when cleaning off tables; things like that."</p> <p>An incident, as reported to the Indiana State Department of Health, was provided by the Executive Director on 5/20/16 at 9:30 a.m. The incident occurred 5/18/16 at 5:01 p.m., and a brief description was "CNA [#14] was observed being rough with care." There was no injury, the CNA was immediately suspended, the Executive Director verbally reported to state surveyors who are in the building for survey, and the police were contacted.</p> <p>A follow up to the incident that occurred on 5/18/16, as reported to the Indiana State Department of Health, and dated 5/21/16, indicated CNA [#14] was</p>		<p>orientation, annually, and as needed. Facility conducted staff and resident interviews. No other residents identified as being affected.</p> <p>Education All Staff to be in-serviced on abuse guidelines including how to report.</p> <p>Monitor ED/DNS/designee to randomly ask staff what they would do if they saw a resident being abused. These audits to occur 3 times weekly x 30 days, 2 times weekly x 30 days, 1 time weekly x 30 days, then 1 time every other week x 30 days, then monthly times 60 days.</p> <p>QAPI Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>reported to the police, and had a case number, the CNA was terminated from the facility, and the resident had no injuries after a head to toe assessment was completed.</p> <p>An interview with the Alzheimer's Care Coordinator was done by the Executive Director as part of Resident #101's investigation, on 5/18/16 at 5:20 p.m. The interview indicated: "She (Alzheimer's Care Coordinator) was standing in the nurses office on the phone w/ (with) [Director of Nurses] and she observed [CNA #14] in the atrium hallway. She said something and then she came up behind [Resident #101] and shoved/pushed her with two hands to where [Resident #101] stumbled and was going forward but was able to self-correct herself and stand up. [Alzheimer's Care Coordinator] saw [Resident #101] looking behind her and then [CNA #14] came around the corner and was pushing another resident in a wheelchair. [Alzheimer's Care Coordinator] was already on the phone with the DNS (Director of Nursing Services) and said "I can't make this up, I just saw [CNA #14] physically push [Resident #101]."</p> <p>Resident #101's record was reviewed on 5/19/2016 at 3:46 p.m. Physician's recapitulation orders for May, 2016</p>			

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	<p>indicated Resident #101 was admitted with diagnoses that included, but were not limited to, Alzheimer's disease, depression, psychosis, gastroesophageal reflux disease, anemia, dementia with behavioral disturbance, pain, angina pectoris, nutritional deficiency, stomach problems and constipation.</p> <p>A quarterly Minimum Data Set assessment (MDS) dated 2/11/16, indicated the resident was severely impaired in cognitive skills for daily decision making, rarely/never understood, and required limited assistance of one person physical assistance.</p> <p>A care plan, last revised 4/8/13, had a focus of : "Resident has DX (diagnosis) of Alzheimer's and Dementia with behavioral disturbances and noted cognitive loss. Goal: Will make daily choices in care. Interventions: Communication train/skill practice: Pt (patient) hard of hearing. Speak loudly, make eye contact, and use gestures if needed when communicating with pt. Give short 1 step directions. Ask simple yes/no questions. Help me maintain my dignity. Help me with reminders and cues as needed. Offer me the opportunity to interact with others at my level. Please encourage me to do what I am capable of</p>			

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	<p>doing. Provide set up, cues, and physical assist for task completion. Please help me make safe choices."</p> <p>A care plan, last reviewed on 11/4/14, indicated a focus of "At risk for falls R/T: HX (history) wandering: cognitive loss with impaired safety awareness; unsteady balance. Goal: No severe fall related injuries. Interventions; Bed against wall. Bed canes as ordered. Call light or personal items available. Footwear to prevent slipping. Keep bed in low position, when resident in bed. Keep environment well lit and free of clutter. Observe for side effects of Medications. Therapy referral as needed."</p> <p>During an observation, on 5/19/2016 at 1:39 p.m., Resident #101 sat in the dining room on her unit, dressed in street clothes. When she was spoken to, she was unable to answer and started fiddling with the table cloth.</p> <p>On 5/19/2016 at 1:49 p.m., Resident #101 was observed walking slowly in the hallway by herself, waved at someone she knew and stopped and smiled at someone else. She was very quiet and no behaviors were observed.</p> <p>On 5/23/2016 at 11:16 a.m., Resident #101 was observed slowly walking by her</p>			

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	<p>room, and would stop and stare at the wall or door.</p> <p>A "Quarterly Interdisciplinary Resident Review" dated 5/10/16, indicated Resident #101 was alert, had a short term memory problem, and a long term memory problem. She needs assist with decisions at this time, she sometimes made herself understood, she was steady at all times for moving from seated to standing position, walking, turning around, moving on and off toilet, and surface to surface transfer, had no impairment with range of motion.</p> <p>During an interview, on 5/24/2016 at 3:16 p.m., Unit Manager #6 indicated after an incident, they do a full head to toe skin assessment to look for bumps, bruises, red marks, anything that isn't normal for that resident. For that incident, she put the information on a shower sheet and gave it to the DoN. She said the Alzheimer's Care Coordinator would follow up by watching for behaviors, tearfulness, and any emotions after the incident and she does a follow up note.</p> <p>A policy and procedure for "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation", with an effective date of 2/12/16, was</p>			

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	<p>provided by the Administrator on 5/19/16. The policy included, but was not limited to, "Policy Statement: It is the responsibility of all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect injuries of unknown source and misappropriation of resident property. It is the policy of this center to take appropriate steps to prevent the occurrence of: Abuse, Neglect, Misappropriation of resident property. Physical abuse includes hitting, slapping, pinching and kicking...."</p> <p>3.1-27(a)(1)</p>						
F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>	F 0226		06/24/2016			

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	<p>Based on record review and interview, the facility failed to implement their policy related to preventing physical abuse (Resident #101), and notification to the physician and family of an abuse allegation in a timely manor. (Resident #J) This affected 2 of 3 residents reviewed for abuse.</p> <p>Findings include:</p> <p>1. During an interview, on 5/19/16 at 2:21 p.m., the Alzheimer's Care Coordinator indicated: "I was in the nursing station on the phone with the [Director of Nursing] (DoN) and I saw [CNA #14] shove [Resident #101]. The resident started to lose her balance and she self corrected but she did not fall, so I reported to the [DoN] while I was the phone with her. I called and told [Unit Coordinator #6]. [CNA #14] then pushed another resident in a wheelchair past [Resident #101]. [The] DoN and me immediately within 5 minutes had her clock out and leave the facility, the CNA [#14] did not say anything she just said "ok". Never witnessed abuse with [CNA #14] before with residents but [she] has a poor attitude, refuses inservices, bangs things when cleaning off tables; things like that."</p> <p>An incident, as reported to the Indiana</p>		<p>Res #101</p> <p>Res J</p> <p>FFTE-policy related to preventing physical abuse implemented for res and notification to the physician and family of an abuse allegation in a timely manor</p> <p>Res Identified</p> <p>CNA #14 suspended immediately following allegation and terminated at completion of investigation. Unable to correct for Res J.</p> <p>Others</p> <p>All staff to be in-serviced on abuse guidelines. Licensed staff in-serviced on physician/family notification guidelines.</p> <p>Education</p> <p>All staff in-serviced on abuse guidelines. Licensed staff in-serviced on physician/family notification guidelines including immediate notification of physician/family on abuse allegations.</p> <p>Monitor</p> <p>ED/DNS/designee to randomly ask</p>	

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	<p>State Department of Health, was provided by the Executive Director on 5/20/16 at 9:30 a.m. The incident occurred 5/18/16 at 5:01 P.M. and a brief description was "CNA [#14] was observed being rough with care." There was no injury, the CNA was immediately suspended, the Executive Director verbally reported to state surveyors who are in the building for survey, and the police were contacted.</p> <p>A follow up to the incident of physical abuse, that occurred on 5/18/16, as reported to the Indiana State Department of Health, and dated 5/21/16, indicated CNA [#14] was reported to the police, and had a case number, the CNA was terminated from the facility, and the resident had no injuries after a head to toe assessment was completed.</p> <p>An interview with the Alzheimer's Care Coordinator was done by the Executive Director as part of Resident #101's investigation, on 5/18/16 at 5:20 p.m. The interview indicated: "She (Alzheimer's Care Coordinator) was standing in the nurses office on the phone w/ (with) [Director of Nurses] and she observed [CNA #14] in the atrium hallway. She said something and then she came up behind [Resident #101] and shoved/pushed her with two hands to</p>		<p>staff what they would do if they saw a resident being abused. These audits to occur 3 times weekly x 30 days, 2 times weekly x 30 days, 1 time weekly x 30 days, then 1 time every other week x 30 days, then monthly x 60 days. Notificaton of physician/family to be documented in investigation and ED/DNS/designee to review every allegation of abuse to ensure physician/family notified in a timely manner.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>where [Resident #101] stumbled and was going forward but was able to self-correct herself and stand up. [Alzheimer's Care Coordinator] saw [Resident #101] looking behind her and then [CNA #14] came around the corner and was pushing another resident in a wheelchair. [Alzheimer's Care Coordinator] was already on the phone with the DNS (Director of Nursing Services) and said "I can't make this up, I just saw [CNA #14] physically push [Resident #101]."</p> <p>Resident #101's record was reviewed on 5/19/2016 at 3:46 p.m. Physician's recapitulation orders for May, 2016 indicated Resident #101 was admitted with diagnoses that included, but were not limited to, Alzheimer's disease, depression, psychosis, gastroesophageal reflux disease, anemia, dementia with behavioral disturbance, pain, angina pectoris, nutritional deficiency, stomach problems and constipation.</p> <p>A quarterly Minimum Data Set assessment (MDS) dated 2/11/16, indicated the resident was severely impaired in cognitive skills for daily decision making, rarely/never understood, and required limited assistance of one person physical assistance.</p> <p>2. Resident #J's record was reviewed on</p>			

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	<p>5/24/16 at 11:08 a.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, Alzheimer's disease, dementia with behavioral disturbances, protein-calorie malnutrition, nutritional deficiency, osteoporosis, and osteoarthritis.</p> <p>Resident #J's significant change MDS assessment dated 2/17/16, indicated she rarely/never understood others. She was severely impaired in her cognitive daily decision making skills. She required extensive assistance of 1 person for bed mobility, dressing, personal hygiene, and eating. She required extensive assistance of 2 persons for transfer and toileting. She required limited assistance of 2 persons for ambulation in her room.</p> <p>An initial "Incident" report provided by the Administrator on 5/19/16 at 9:30 a.m., indicated on 5/18/16 at 3:25 p.m., an allegation had been reported to an Indiana State Department of Health (ISDH) Surveyor of rough treatment by CNA #12 during care of Resident #J. The ISDH Surveyor had reported the allegation to the facility. A head to toe assessment had been completed by the facility for Resident #J and CNA #12 had been suspended pending an investigation.</p>			

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	<p>A "Progress Note" for Resident #J dated 5/23/16 at 2:50 p.m., indicated on 5/23/16 at 12:20 p.m., Resident #J's husband had been notified and at 2:30 p.m., the physician had been notified of the allegation reported to the facility of the abuse allegation against CNA #12 on 5/18/16.</p> <p>A follow-up "Incident" report provided by the Administrator on 5/25/16 at 2:30 p.m., indicated on 5/21/16, CNA #12 had been terminated from employment. Resident #J had no injuries observed during her head to toe assessment.</p> <p>An interview with Confidential Family Member #19 on 5/18/16 at 3:00 p.m., indicated approximately 2 to 3 months prior she had observed CNA #12 grab a fork and spoon out of Resident #J's hand real hard and said "we are not going to play these games." Confidential Family Member #19 indicated staff had to feed Resident #J and she had felt like CNA #12 had been mean to Resident #J.</p> <p>An interview with the Administrator on 5/23/16 at 1:48 p.m., indicated the facility had been unable to substantiate the allegation of abuse against CNA #12. She indicated CNA #12 had been terminated.</p>			

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	<p>On 5/23/16 at 2:59 p.m., the Director of Nursing indicated she had just notified the physician and Resident #J's family of the allegation of abuse against CNA #12 reported to the Administrator on 5/18/16.</p> <p>A policy and procedure for "Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation", with an effective date of 2/12/16, was provided by the Administrator on 5/19/16. The policy included, but was not limited to, "Policy Statement: It is the responsibility of all employees to immediately report any reasonable suspicion of a crime, alleged violation of abuse, neglect injuries of unknown source and misappropriation of resident property. It is the policy of this center to take appropriate steps to prevent the occurrence of: Abuse, Neglect, Misappropriation of resident property...Physical abuse includes hitting, slapping, pinching and kicking...Investigation...The physician will be notified of the allegation as soon as practicable possible...The DNS, or his/her designee, notifies the resident's representative regarding the alleged violation and assessment findings and reassures the resident's representative that an investigation has been initiated and appropriate action will be taken...."</p>				

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F 0242 SS=D Bldg. 00	<p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review the facility failed to determine a resident's preference of how many shower a week she desired to have which resulted in the resident not receiving showers as she preferred for 1 of 6 residents who met the criteria for choices of 3 residents reviewed for choices (Resident #1).</p> <p>Finding include:</p> <p>Interview with Resident #1 on 05/18/2016 at 10:50 a.m., indicated she did not get to choose how many times a week she received a shower. The resident indicated</p>	F 0242	<p>Res I</p> <p>FFT-determine a resident's preference of how many showers a week she desired to have which resulted in the resident not receiving showers as she preferred for 1/6 residents who met the criteria for choices of 3 res reviewed for choices.</p> <p>Res Identified</p> <p>A resident preference sheet</p>	06/24/2016	

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	<p>she received two showers a week and would like to have more. The resident indicated she had problems with urinary and bowel incontinence and therefore felt it was important to have more showers. The resident indicated when she was at home she took a shower every day but would like to have at least 6 showers a week.</p> <p>Review of the record of Resident #I on 5/23/16 at 11:10 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinson, depression, anxiety, pain, insomnia, dementia, hypertension and osteoarthritis.</p> <p>The Annual Minimum Data Set (MDS) assessment for Resident #I, dated 4/20/16, indicated the resident had the ability to understand others and was able to make herself understood. It was very important for the resident to choose between a tub bath, shower, bed bath or a sponge bath. The resident was totally dependent for bathing. She was frequently incontinent of her bladder.</p> <p>The careplan for Resident #I, dated 8/25/14, indicated the resident had physical functioning deficit related to Parkinson with self care impairment. The interventions included, but were not limited to, personal hygiene assistance.</p>		<p>completed on Res I and CNA assignment sheet updated to reflect Res I shower preferences.</p> <p>Others</p> <p>All interviewable residents interviewed for preferences regarding showers, families will be interviewed, if available, on non interviewable residents. CNA assignment sheets will be updated based on resident's preferences.</p> <p>Education</p> <p>Nursing staff in-serviced that Director of Resident Assessment (DORA)/designee to complete resident preference on admission. Once completed, the preference sheet to be given to UM/designee to update CNA assignment sheet with resident shower preferences. The preference sheet to be reviewed/updated with care plans following MDS schedule.</p> <p>Monitor</p> <p>UM/designee to review each new admission to ensure preference sheet completed and CNA assignment sheet updated with resident's shower preference. These audits to be completed 5 times weekly x 30 days, 3 times weekly x</p>	

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	<p>Review of Resident #I's shower sheets, dated 4/23/16 to 5/22/16, indicated the resident received 5 showers and 4 full bed baths.</p> <p>Interview with the MDS coordinator #4 on 5/23/16 at 11:38 a.m., indicated she was responsible to fill out preferences sheets on admission for how often residents preferred a shower and then gave them to the Unit Managers. MDS coordinator #4 indicated if a resident had been at the facility a long time then Social Services would be responsible to fill out an updated preference sheet for showers. MDS coordinator #4 indicated she put the orders in the care tracker system.</p> <p>Interview with the Administrator on 5/24/16 at 1:00 p.m., indicated a preference sheet for showers was not completed for Resident #I.</p> <p>3.1-3(u)(1)</p>		<p>30 days, then weekly x 90 days.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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F 0244 SS=D Bldg. 00	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on interview and record review the facility failed to act upon and resolve resident council concerns of call lights not being answered timely for 3 of 12 months of resident council meetings reviewed.</p> <p>Findings include:</p> <p>Review of the resident council minutes on 5/24/16 at 9:30 a.m., indicated the following: The resident council minutes, dated 3/10/16 at 2:30 p.m., "new business" were "call lights not being answered for an extended period of time." The documentation indicated there were 6 of 12 residents who shared this concern. There was no department response completed for this concern. The documentation for the department response was blank.</p> <p>The resident council minutes, dated 4/25/16 at 2:30 p.m., indicated the "old business" of "call lights not being</p>	F 0244	<p>Res Act upon and resolve a resident council concern of call lights not being answered timely for 3 of 12 months of resident council meetings reviewed</p> <p>Res Identified Unable to correct</p> <p>Others All residents have the potential to be affected by this deficiency.</p> <p>Education Department heads in-serviced on process for responding to concerns voiced in resident council. Activity Director heads the resident council and fills out the initial response form for any grievances voiced during meeting. Activity Director to bring response forms to morning meeting following resident council and hand out and discuss concerns from resident council meeting. Appropriate Department heads to respond to concerns and turn in their corrective actions taken. Call light audits conducted and on-going.</p> <p>Monitor ED/designee to monitor that response forms are completed with corrective action</p>	06/24/2016			

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	<p>answered for an extended period of time" indicated the issue was not resolved to the resident council's satisfaction. The documentation indicated there were 10 of 16 residents attending the resident council meeting that shared this concern. The documentation for "department response" was blank.</p> <p>The resident council minutes, dated 5/19/16 at 2:30 p.m., indicated the "old business" of "call lights not being answered for an extended period of time" was not resolved to the resident council's satisfaction. The documentation indicated there were 10 of 10 residents attending the resident council meeting that shared this concern. The documentation for "department response" was blank.</p> <p>An interview with the Activity Director #5 on 5/24/16 at 10:13 a.m., indicated she gave the concern from Resident Council to the Director Of Nursing (DON) related to call lights not being answered. Activity Director #5 indicated she had not received a response back related to this issue and it was still unresolved. Activity Director #5 indicated she had given the DON the March 2016, April 2016 and May 2016 the call light concerns.</p> <p>In an interview with the DON on 5/24/16</p>		<p>and turned back in to Activity Director. These audits to be completed monthly after resident council meeting has taken place.</p> <p>The facility will monitor call light timeliness through guardian angel rounds, family/resident grievance process, and call light audits. Random call light audits to be conducted by department head 5 times weekly x 90 days then 3 times weekly times 90 days.</p> <p>QAPI Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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F 0246 SS=E Bldg. 00	<p>at 10:21 a.m., indicated the facility had verbally went around and talked to the aides and the nurses and reminded them they need to answer call lights. The DON indicated she was aware the call light issue had not been resolved.</p> <p>This Federal tag relates to Complaint IN00197809.</p> <p>3.1-3(I)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review, the facility failed to have adequate nursing staff to assist residents to the restroom, provide incontinence care timely, answer call lights timely and assist residents with eating for 8 of 12</p>	F 0246	Res B, D, G, H, I, J, L, M	06/24/2016

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	<p>residents reviewed for staffing (Resident #L, Resident #M, Resident #G, Resident #I, Resident #D, Resident #H, Resident #B and Resident #J).</p> <p>Findings include:</p> <p>1.) Interview with Resident #L on 05/18/2016 at 10:30 a.m., indicated she did not feel there was enough staff available to give her the care and assistance she needed. The resident indicated she had become incontinent due to waiting for assistance to the bathroom. The resident indicated it took 30 minutes or longer to have her call light answered.</p> <p>Review of the record Resident #L on 5/23/16 at 1:36 p.m., indicated the resident's diagnoses included, but were not limited to, Parkinson, depression, urgency of urination, osteoarthritis, overactive bladder, dementia, anxiety and hypertension.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #L, dated 4/27/16, indicated the resident had the ability to understand others and was able to be understood. The resident required extensive assistance of two people to transfer and for toilet use.</p>		<p>Facility failed to ensure to have adequate nursing staff to assist residents to the restroom, provide incontinence care timely, answer call lights timely and assist residents with eating for 8 of 12 residents reviewed for staffing</p> <p>Res Identified</p> <p>Unable to correct for identified residents.</p> <p>Others</p> <p>All residents have the potential to be affected. Resident interviews conducted and grievances reviewed. Last three months of resident council minutes reviewed with any issues addressed as needed.</p> <p>Education</p> <p>Nursing staff in-serviced that all units need to have adequate staff available on each unit to assist residents with care. Nursing staff to notify ED/DNS/designee when there is not adequate staffing available for each unit.</p> <p>Monitor</p>	

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	<p>2.) Interview with Resident #M on 05/18/2016 at 11:36 a.m., indicated he did not feel there was enough staff available to give the care and assistance he needed. The resident indicated he understood staff were busy and was taking care of other residents. The resident stated "why should I have to wait a half an hour to get help."</p> <p>Review of the record of Resident #M on 5/23/16 at 2:25 p.m., indicated the resident's diagnoses included, but were not limited to, hemiplegia, Parkinson disease, depression, weakness, chronic kidney disease, anxiety, insomnia, type two diabetes and tremors.</p> <p>The Quarterly MDS assessment for Resident #M, dated 3/9/16, indicated the resident had the ability to understand others and was able to be understood. The resident was cognitively intact, decisions were reasonable. The resident required extensive assistance with transfers and extensive assistance of one person to use the restroom.</p> <p>3.) Interview with Resident #G on 05/18/2016 at 11:13 a.m., indicated she did not feel there was enough staff available to give her the care and assistance she needed. The resident indicated she had to wait an hour and 15</p>		<p>ED/DNS/Designee will meet 5 times weekly and review daily staffing schedules to ensure adequate staffing is available on each unit.</p> <p>ED/designee to interview three residents/families per week x6 months to monitor for the deficient practice. Any concerns voiced will be addressed through the family/resident grievance process.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>minutes to get her call light to be answered for assistance to the bathroom. The resident indicated when she was admitted to the facility she wore her own underwear, but she would have to change her clothes from becoming incontinent so often she decided to start wearing briefs so her clothes would not get ruined. The resident indicated she knew when she needed to go to the bathroom, but could not hold it that long. The resident indicated when she did receive assistance to the bathroom she would have to wait on the toilet for a long time for staff to come back and assist her up. The resident indicated it was uncomfortable to sit on the toilet for a long time because she had arthritis.</p> <p>Interview with Resident #G on 5/19/16 at 1:15 p.m., indicated she had been timing how long it took for her call light to be answered by the clock in her room. The resident indicated the other day it took and hour for the call light to be answered. The resident indicated staff told her it took that long because they were in shift change. The resident indicated waiting so long had caused her to start being incontinent of her bowels and her bladder. The resident indicated it took one aide to help her to the bathroom because she was weak.</p>			

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	<p>Review of Resident #G's record on 5/19/16 at 3:26 p.m., indicated the resident's diagnoses included, but were not limited to, insomnia, history of urinary tract infection, osteoarthritis, fatigue, hypertension, anemia, spinal stenosis and heart failure.</p> <p>The Admission MDS assessment for Resident #G, dated 3/18/16, indicated she had the ability to understand others and make herself understood. The resident was reasonable and consistent with decisions of daily decision making. The required limited assistance of one person to use the bathroom. The resident was occasionally incontinent of her bladder and bowels.</p> <p>4.) Interview with Resident #I on 05/18/2016 10:55 a.m., indicated she did not feel there was enough staff available to give her the care and assistance she needed.</p> <p>The resident indicated she had waited for an hour laying in bed wet from urine. The resident indicated it was "horrible waiting for someone to help you get cleaned up".</p> <p>Review of the record of Resident #I on 5/23/16 at 11:10 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinson, depression, anxiety, pain, insomnia, dementia,</p>			

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	<p>hypertension and osteoarthritis.</p> <p>The Annual MDS assessment for Resident #I, dated 4/20/16, indicated the resident had the ability to understand others and was able to make herself understood. The resident was totally dependent for bathing. She was frequently incontinent of her bladder and occasionally incontinent of her bowels. The resident required extensive assistance of one person to transfer, ambulate and use the bathroom.</p> <p>5.) Interview with Resident #D on 5/19/16 at 1:31 p.m., indicated the time it takes for her call light to be answered varied. The resident indicated at noon it was almost impossible to get help from staff. The resident indicated it took too long for her call light to be to answered and sometimes she would yell out "help" . The resident indicated she had become incontinent of her urine because she had to wait for assistance.</p> <p>Review of the record of Resident #D on 5/19/16 at 2:32 p.m., indicated the resident's diagnoses included, but were not limited to, cerebral ischemia, UTI (5/14/16), constipation, overactive bladder, dementia without behavioral disturbance, osteoarthritis, and hypertension.</p>			

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	<p>The Annual MDS assessment for Resident #D, dated 3/22/16, indicated she had the ability to understand others and make herself understood and was cognitively intact for daily decision making. She required extensive assistance of one person to use the restroom. The resident was frequently incontinent of her bowels and bladder.</p> <p>Interview with Resident #D's Family member on 5/20/16 at 10:00 a.m., indicated there were clearly not enough staff at the facility. The Family member indicated she visited her family member every day. The Family member indicated the resident was unable to go to the restroom by herself and she "constantly" came in and found the resident sitting wet with urine. The Family member indicated when the resident turns on her call light no one comes, so the Family member had to walk down the hallways looking for staff and often is not able to find any staff.</p> <p>Interview with Confidential staff #1, indicated the facility did not have enough staff to assist residents to the bathroom. Confidential staff #1 indicated staff were unable to assist "residents to the bathroom this results in falls, residents trying to take themselves."</p>			

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	<p>Interview with Confidential staff #2, indicated there was not enough staff to assist residents with incontinence care and the residents set for long periods of time wet. Confidential staff #2 indicated it took between 30-45 minutes to answer call lights. Confidential staff #2 indicated there was not enough staff to assist residents with eating and the residents food would sit for 30-45 minutes before staff were able to feed them. Confidential staff #2 indicated there was not enough staff to assist residents to the restroom, change bed linens and assist residents to lay down. Confidential staff #2 indicated residents were left sitting up for long periods of time.</p> <p>Review of the resident council minutes on 5/24/16 at 9:30 a.m., indicated the following: The resident council minutes, dated 3/10/16 at 2:30 p.m., indicated "new business" were "call lights not being answered for an extended period of time." There were 6 of 12 residents who shared this concern. The documentation indicated there were no response from the department completed.</p> <p>The resident council minutes, dated 4/25/16 at 2:30 p.m., indicated the "old business" of "call lights not being answered for an extended period of time"</p>			

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	<p>The documentation indicated the issue was not resolved to the resident council's satisfaction. There were 10 of 16 residents attending the resident council meeting that shared this concern. The documentation for "department response" was blank.</p> <p>The resident council minutes, dated 5/19/16 at 2:30 p.m., indicated the "old business" of "call lights not being answered for an extended period of time" was not resolved to the resident council's satisfaction. There were 10 of 10 residents attending the resident council meeting shared that shared this concern. The documentation for "department response" was blank.</p> <p>6. During an interview, on 5/18/16 at 3:11 p.m., Resident #H indicated there is not enough staff and said if he turns the call light on during the day it's ok, but at night it can take two to three hours for the call light to be answered. He said yesterday evening his roommate got back to his room, after supper, at 7:20 p.m. and it was two hours before staff came in to answer his call light.</p> <p>Resident #H's record was reviewed on 5/20/2016 at 11:14 a.m. The May, 2016 physician's recapitulation orders indicated Resident #H had diagnoses that included,</p>			

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	<p>but were not limited to, alcohol dependence with alcohol-induced persisting dementia, depression, angina pectoris, peripheral vascular disease, protein-calorie malnutrition, anemia, chronic pain, nutritional deficiency, high blood pressure, insomnia, and osteoporosis.</p> <p>An Annual Minimum Data Set assessment (MDS), dated 5/4/16, indicated resident #H was cognitively intact.</p> <p>7. An interview with Resident #B's son on 5/20/16 at 10:16 a.m., indicated "the only problem is they don't have enough aides to help out. The ones that are here are overworked." He indicated he visit his mother every other day. He indicated it looked like the staff were in a hurry and didn't clean up like they should and his mothers bed wasn't made half the time.</p> <p>An interview with Resident #B's daughter on 5/23/16 at 10:00 a.m., indicated when she came to visit her mother was usually left sitting in the dining room or in the hallway. "They are just overworked and under staffed."</p> <p>On 5/23/16 at 11:33 a.m., Resident #B was observed being assisted into bed for incontinence care by CNA #16 and LPN</p>			

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	<p>#13 with the use of a Marissa Lift. Resident #B's brief was wet with urine. CNA #16 indicated Resident #B's brief had last been changed when she showered her at 7:30 a.m., that morning.</p> <p>An interview with CNA #16 on 5/23/16 at 11:49 a.m., indicated a resident who was incontinent should be changed approximately every 2 hours. She indicated she believed there were not enough staff to care for the residents timely and properly, "because you rush, rush, rush." She indicated she did not have enough time to change all her incontinence residents every 2 hours.</p> <p>Resident #B's record was reviewed on 5/24/16 at 12:18 p.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, dementia without behavioral disturbances, anxiety disorder depressive episodes, nutritional deficiencies, muscle weakness, athrosclerosis, osteoarthritis, respiratory disorder, pain, disorder of the kidney and ureter, and disorder of the skin and subcutaneous tissue.</p> <p>Resident #B's significant change MDS assessment dated 4/15/16, indicated she sometimes was understood and she sometimes understood others. She was</p>			

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	<p>severely impaired in her cognitive daily decision making skills She required extensive assistance of 1 person for bed mobility, dressing, eating, and personal hygiene. She required extensive assistance of 2 persons for transfer and toileting. She did not walk. She was always incontinent. She was a Hospice resident.</p> <p>8. An interview with Resident #J's spouse on 5/17/16 at 2:41 p.m., indicated his wife had a UTI. He indicated his wife usually had her brief changed daily around 9:00 a.m., and then again around 2:00 p.m., to 2:30 p.m. He indicated he was at the facility daily from 10:00 a.m., until 3:00 p.m.</p> <p>An interview with Resident #J's spouse on 5/17/16, at 2:58 p.m., indicated he did not feel there were enough staff to assist the resident without them having to wait a long time. "During lunch, most generally. Today was an exception because you are here. There is generally 4 residents who need fed in dining room where my wife eats." He indicated he fed his wife and she ate in the middle dining room (dining room #2) on the AACU unit. He indicated he generally took care of a resident who sat on his right. He generally cut up her food because she ate with her hands. If the facility served her</p>			

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	<p>something she couldn't eat with her hands he fed the food to her. "I assist her because no staff come in and assist her. Today 1 staff was assisting the resident to eat, I had never seen her feed the residents before in that middle dining room." He indicated staff would place his wife's roommates (Resident #B) food on the table and let it sit for at least 30 minutes before anyone attempted to feed her. There was generally only 1 staff assisting in dining room #2 and were busy assisting other residents. "There was staff doing things today I have never seen them do before. There was staff working in the dining room that I had never seen before, and they didn't know what to do with the residents."</p> <p>On 5/20/16 at 2:01 p.m., Resident #J was observed being toileted. Resident #J's slacks were wet front and back. CNA #15 and Resident #J's spouse assisted Resident #J to ambulate to the toilet. Her soiled brief was removed by CNA #15 and was soaked with urine. Resident #J urinated in the toilet. CNA #15 indicated she had not changed Resident #J's brief since she arrived at work around 10:35 a.m. Resident #J's spouse indicated he arrived at the facility at 10:00 a.m., and his wife's brief had not been changed since he had been there.</p>			

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	<p>On 5/20/16 at 2:26 p.m., Resident #J's spouse indicated he did not feel there were enough staff to care for the residents. He was unsure if his wife was on any type of toileting program but he would like her to be toileted every 2 hours. He believed his wife not being toileted often enough contributed to her UTI's. His wife has had several UTI's since she had lived at the facility.</p> <p>Resident #J's record was reviewed on 5/24/16 at 11:08 a.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, Alzheimer's disease, dementia with behavioral disturbances, protein-calorie malnutrition, nutritional deficiency, osteoporosis, and osteoarthritis.</p> <p>Resident #J's significant change MDS assessment dated 2/17/16, indicated she rarely/never understood others. She was severely impaired in cognitive daily decision making skills. She required extensive assistance of 1 person for bed mobility, dressing, personal hygiene, and eating. She required extensive assistance of 2 persons for transfer and toileting. She required limited assistance of 2 persons for ambulation in her room. She was frequently incontinent and was not on a toileting program.</p>			

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	<p>A physician's order for Resident #J dated 5/13/16 at 6:03 p.m., indicated she would receive Rocephin 1 gram intramuscularly 1 time a day for 5 days for a UTI.</p> <p>9. An observation of resident dining was conducted on 5/20/16 at 1:01 p.m., in dining room #3 on the AACU unit. CNA #15 was observed assisting 4 residents seated at one table with their meals. She was walking around the table picking up the residents utensils and giving them a bite of their food and encouraging them to eat. She was touching the residents backs and wheelchairs as she made her way around the table. She picked up one of the resident's sandwich and gave her a bite. She walked over to another table encouraged them to eat and drink.</p> <p>An interview with Unit Coordinator #6 on 5/20/16 at 1:30 p.m., indicated the facility did not have enough staff to feed the residents timely because there were a lot of residents who needed assistance. There were 32 residents on the AACU unit and 13 of those residents required being fed and 6 residents required prompts and cues. She typically had 1 CNA in dining room #1, a nurse in dining room #2, and a CNA in dining room #3. She indicated 1 or 2 members of management assisted in dining room #1,</p>			

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F 0279 SS=D Bldg. 00	<p>and the ACD Director assisted in dining room #1 and then in dining room #3. She herself assisted in dining room #2 and ended up assisting in dining room #3.</p> <p>An interview with the ACD Director on 5/20/16 at 2:49 p.m., indicated she felt like there were enough staff to feed the residents timely. "We certainly could use more, so the staff who is feeding 3 resident at a time could focus on 2 residents. All we can do is pitch in and help each other. We go from table to table to make sure the residents are not neglected and there is no oversight."</p> <p>This federal tag relates to Complaint IN00197809.</p> <p>3.1-3(v)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the</p>			

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	<p>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 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 observation, interview and record review, the facility failed to develop a plan of care and implement interventions for non-pressure related skin injuries for a resident with an injury to her forehead and right hand (Resident #B) and Urinary Tract Infections (UTI's) for a resident with chronic UTI's (Resident #D) for 2 of 23 residents reviewed for care plans.</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 5/24/16 at 12:18 p.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, dementia without</p>	F 0279	<p>Res B, D</p> <p>FFT-develop a plan of care and implement interventions for non-pressure related skin injuries for a resident with an injury to her forehead and right hand and UTI's for a resident with chronic UTI's for 2/23 residents reviewed for care plans</p> <p>Res Identified</p> <p>Care plans for Res B and Res D reviewed and updated</p> <p>Others</p>	06/24/2016

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	<p>behavioral disturbances, anxiety, disorder of the skin and subcutaneous tissue, nutritional deficiencies, and muscle weakness.</p> <p>A "Progress Note" for Resident #B dated 3/14/16 at 3:57 p.m., indicated she had sutures intact to the center of her forehead. She had bruising over the top of her right hand and into her fingers from a previous fall.</p> <p>A "Weekly Skin Review" for Resident #B dated 3/28/16 at 4:40 p.m., indicated a scabbed area remained to her forehead from a previous fall.</p> <p>Resident #B's significant change Minimum Data Set (MDS) assessment dated 4/15/16, indicated she sometimes was understood and she sometimes understood others. She was severely impaired in her cognitive daily decision making skills. She required extensive assistance of 1 person for bed mobility, dressing, eating, and personal hygiene. She required extensive assistance of 2 persons for transfer and toileting. She did not walk. She had no impairment in her range of motion. She had no skin tears or other wounds except pressure ulcers. She was a Hospice resident.</p> <p>A "Progress Note" for Resident #B dated</p>		<p>Residents identified with chronic UTI's and who have non-pressure related skin injuries reviewed and updated as needed.</p> <p>Education</p> <p>DORA in-serviced on ensuring careplans are updated per RAI process and as needed with any change in status.</p> <p>Monitor</p> <p>IDT to review care plans with every MDS assessment and ensure careplan has been developed as appropriate. These audits to be conducted based on MDS schedule.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>5/23/16 at 3:15 p.m., indicated she had a skin tear to the top of her right hand. She had poor safety awareness and thin fragile skin. The skin tear measured 1.0 centimeter (cm) by 1.0 cm with no active bleeding. The skin tear was cleansed with wound cleanser, steri-stips were applied, bacitracin ointment was applied, and the wound was covered with a dressing.</p> <p>No plan of care was available in Resident #B's record for non-pressure related injuries.</p> <p>On 5/18/16 at 12:52 p.m., Resident #B was observed seated in a geriatric chair in her bedroom. She had a dark scabbed area approximately the size of a nickel in the center of her forehead near her hairline. She was covered with a lap blanket. She was non-verbal to conversation.</p> <p>On 5/20/16 at 10:16 a.m., Resident #B was observed seated in a geriatric chair in her bedroom. She was wearing a long sleeve blouse and slacks. The top of both hands were light purplish in color. She had a dark scabbed area approximately the size of a nickel in the center of her forehead near her hairline. Her son was in her room visiting. Her son believed the purplish discolorations were natural</p>						

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	<p>in color for his mother. He indicated his mother got bruises periodically on the top of her hands and arms but he hadn't noticed any lately. He indicated the scab on her forehead was from where she had fallen out of standard wheelchair approximately 2 months prior.</p> <p>On 5/23/16 at 10:00 a.m., Resident #B was observed seated in a geriatric chair in her bedroom. She had bilateral arm tremors. She was dressed in a short sleeve blouse and slacks and covered with a lap blanket. She had scattered areas of discolorations on top of both hands and arms. She had a skin tear approximately an inch long on the top of her right hand with a red wound bed and purplish discoloration surrounding the skin tear. Resident #B's daughter and son were in her room visiting. Resident #B's daughter indicated her mother took an aspirin daily and periodically had areas of discoloration on her arms and hands.</p> <p>On 5/23/16 at 10:32 a.m., LPN #13 measured Resident #B's skin tear on top of her right hand. She cleansed the wound with wound cleanser, applied 2 steri-strips, applied bacitracin, and applied a dressing.</p> <p>On 5/25/16 at 10:54 a.m., MDS Coordinator #4 indicated Resident #B did</p>			

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	<p>not have a non-pressure injury plan of care. She indicated if a resident received a skin tear or had a rash or anything else that a resident had a treatment for then she would initiate a plan of care. She indicated she did not initiate a non-pressure plan of care unless a resident had a treatment.</p> <p>2.) Review of the record of Resident #D on 5/19/16 at 2:32 p.m., indicated the resident's diagnoses included, but were not limited to, cerebral ischemia, UTI (5/14/16), constipation, overactive bladder, dementia without behavioral disturbance, osteoarthritis, and hypertension.</p> <p>The Annual MDS assessment for Resident #D, dated 3/22/16, indicated she had the ability to understand others and make herself understood and was cognitively intake for daily decision making. She required extensive assistance of one person to use the restroom. The resident was frequently incontinent of her bowels and bladder.</p> <p>Resident #D was ordered Ceftin 500 milligrams (mg) on 5/14/16 at 6:02 p.m. for a Urinary Tract Infection (UTI) for 7 days and Florestor 250 mg for 14 days.</p> <p>Resident #D was ordered doxycycline</p>				

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	<p>100 mg two times a day for 10 days for a UTI on 2/3/16.</p> <p>Resident #D was ordered augmentin 875-125 two times a day for a UTI on 12/20/15.</p> <p>Resident #D was ordered cipro 250 mg three times a day for 10 days for a UTI on 12/2/15.</p> <p>The Careplan for Resident #D, dated of 12/15/14, indicated alteration in elimination of bowel and bladder functional incontinence and constipation. The interventions were bowel medication as ordered, observe use and effectiveness, call bell within reach and reminders to use as needed, labs as ordered, observe bowel status frequency, observe for and report signs and symptoms of UTI changes in color odor, or consistency of urine, dysuria, frequency, fever, pain, provide easy access to clothing, provide toileting assistance, thorough incontinence care, use of briefs/pads for incontinence protection and to maintain dignity as requested.</p> <p>Interview with Resident #D's Family member on 5/20/16 at 10:00 a.m., indicated the resident had UTI's all the time.</p>			

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F 0309 SS=G Bldg. 00	<p>Interview with the Director Of Nursing (DON) on 5/24/16 at 10:15 a.m., indicated there was not a plan of care with interventions being proactive in preventing Resident #D's chronic UTI's. The DON indicated it would be the responsibility of the Registered Dietician (RD) or the MDS coordinator to implement the interventions during the routine careplan reviews.</p> <p>3.1-31(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, interview and record review, the facility failed to provide pain medication to a resident prior to a dressing change, resulting in extreme pain for 1 of 1 residents reviewed for hospice. (Resident #B)</p>	F 0309	<p>Res B</p> <p>FFT-provide pain medication to a resident prior to a dressing, resulting in extreme pain for 1 of 1 residents</p>	06/24/2016

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	<p>Findings include:</p> <p>Resident #B's record was reviewed on 5/24/16 at 12:18 p.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, dementia without behavioral disturbances, anxiety, disorder of the skin and subcutaneous tissue, unstageable pressure ulcer, and pain.</p> <p>Resident #B's significant change Minimum Data Set (MDS) assessment dated 4/15/16, indicated she sometimes was understood and she sometimes understood others. She was severely impaired in her cognitive daily decision making skills She required extensive assistance of 1 person for bed mobility, dressing, eating, and personal hygiene. She required extensive assistance of 2 persons for transfer and toileting. She did not walk. She had no impairment in her range of motion. She was not on a scheduled pain medication. She had received no as needed (PRN) pain medication She had 3 stage II ulcers. She was a Hospice resident.</p> <p>An order for Resident #B documented on her May 2016 physician's recapitulation orders, initiated 3/13/13, indicated she would receive 650 milligrams (mg) of</p>		<p>reviewed for hospice</p> <p>Res Identified</p> <p>New order obtained from hospice on 5/23/16 for morphine sulfate 0.25mg every 4 hours prn and 1 hour prior to dressing change for Res B.</p> <p>Others</p> <p>All residents with dressing change orders reviewed to ensure pain medication available prior to dressing change if needed. A pain medication order obtained for any resident identified to be without one.</p> <p>Education</p> <p>Nursing staff in-serviced on pain management guidelines and licensed staff in-serviced on offering a pain medication prior to a dressing change.</p> <p>Monitor</p> <p>DNS/designee to watch a dressing change being completed to ensure residents were asked if they needed pain med prior to tx. These audits to be completed 3 x weekly x 60 days, 2 times weekly x 60 days then weekly</p>	

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	<p>Tylenol every 4 hours PRN for atherosclerosis and fever.</p> <p>A plan of care for Resident #B initiated 4/12/16, indicated she was on hospice related to end of life care. Her goal indicated she would be comfortable and have her needs met. An intervention was to evaluate the effectiveness of medications/interventions to address comfort.</p> <p>A significant change "Clinical Health Status" assessment dated 4/13/16, indicated her pain was 5 on a 0-10 pain scale. Her negative vocalization indicated an "occasional moan or groan. Low level speech with a negative or disapproving quality." Her facial expression indicated "sad, frightened, frown." Her body language indicated "rigid. Fist clenched, knees pulled up. Pulling or pushing away. Striking out."</p> <p>A "Wound Evaluation Flow Sheet" for Resident #B signed 5/20/16, indicated she had a 2.0 centimeter (cm) long by 1.1 cm wide by 0.1 cm deep pressure ulcer on her left second toe identified in the facility on 4/11/16. Her pain was 1.5 on a pain scale of 0 to 10.</p> <p>A "Wound Evaluation Flow Sheet" for Resident #B signed on 5/20/16, indicated</p>		<p>x 60 days.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>she had a 0.8 cm long by 0.9 cm wide by 0.2 cm deep pressure ulcer on her left great toe identified in the facility on 4/13/16. Her pain was 6 on a pain scale of 0 to 10.</p> <p>Resident #B's medication record indicated she had not received any Tylenol PRN medication in May 2016.</p> <p>A physician's order for Resident #B dated 5/24/16 at 12:45 p.m., indicated she would receive 0.25 milliliters (ml) of Morphine Sulfate (concentrate) solution sublingual (SL) every day shift every 3 days 1 hour prior to her dressing change on her left toes and 0.25 ml SL every 4 hours PRN for pain.</p> <p>On 5/23/16 at 10:50 a.m., the Assistant Director of Nursing (ADON) was observed providing wound care to Resident #B's left great toe and left second toe. The ADON removed her soiled dressings from her left great toe and left second toe. Blood was visible on her toes and her toes laid against each other. The ADON sprayed her toes with wound cleanser and cleaned her toes with sterile gauze. Resident #B kept her eyes closed as she winced, moaned, and yelled out in pain. The ADON rubbed the inner left great toe and inner left second toe with skin-prep wipes. Resident #B</p>			

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	<p>continued to keep her eyes closed as she winced, moaned, and yelled out in pain. The wound on her inner left great toe had a whitish/yellowish wound bed and the wound on her inner left second toe had a red wound bed with bloody drainage. There was a foul odor from the wounds. Tegaderm foam adhesive dressings were applied to the inner left great toe and inner left 2nd toe.</p> <p>On 5/23/16 at 11:56 a.m., Unit Coordinator #6 indicated the Hospice Nurse ordered Morphine to be given to Resident #B 1 hour prior to her dressing change and PRN.</p> <p>An interview with the ADON on 5/23/16 at 1:00 p.m., indicated he provided Resident #B with her dressing change the majority of the time and Unit Coordinator #6 provided Resident #B with her dressing change sometimes. He indicated he had never noticed Resident #B show any signs or symptoms of pain prior to this day. He indicated he had notified the Hospice Nurse Resident #B showed signs of pain during her dressing change.</p> <p>An interview with Unit Coordinator #6 on 5/23/16 at 1:04 p.m., indicated she had provided Resident #B with her dressing change sometimes. She stated "I have seen her grimace or say oh, but I</p>			

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	<p>had never seen her holler out like she did today." She indicated when Resident #B had showed signs of pain in the past she had asked Resident #B is she needed something for pain and Resident #B had always told her "no".</p> <p>The "Pain Management Guideline" provided by the Administrator on 5/25/16 at 11:33 a.m., indicated the following: Guideline Statement: To provide guidance for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life, in concert with the patient's/resident's plan of care and goals for pain management. Guidelines: Functions of appropriate pain management include, but are not limited to: Ensuring involvement of patient/resident in pain management. Recognizing and reporting pain as a 5th vital sign. Assessing pain and evaluating response to pain management interventions using a pain management scale based on patient/resident self-report or objective assessment for the cognitively impaired. Intervening to treat pain before the pain becomes severe. Anticipating pain during activities that may be uncomfortable (i.e. dressing changes, transfers, bathing) and pre-treating with pain medication...."</p>			

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F 0314 SS=D Bldg. 00	<p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure 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. Based on observation, interview, and record review, the facility failed to follow a physician's order and plan of care to apply toe spacers between a resident's toes at all times to reduce pressure and promote healing for 1 of 3 residents reviewed for pressure ulcers of 3 who met the criteria for pressure ulcers. (Resident #B)</p> <p>Findings include:</p>	F 0314	<p>Res B</p> <p>FFT-follow a physician's order and plan of care to apply toe spacers between a resident's toes at all times to reduce pressure and promote healing for 1 of 3 residents reviewed for pressure ulcers</p> <p>Res Identified</p>	06/24/2016			

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	<p>Resident #B's record was reviewed on 5/24/16 at 12:18 p.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, dementia without behavioral disturbances, nutritional deficiencies, muscle weakness, peripheral vascular disease, disorder of the skin and subcutaneous tissue, and an unstageable pressure ulcer.</p> <p>Resident #B's significant change Minimum Data Set (MDS) assessment dated 4/15/16, indicated she sometimes was understood and she sometimes understood others. She was severely impaired in her cognitive daily decision making skills She required extensive assistance of 1 person for bed mobility, dressing, eating, and personal hygiene. She required extensive assistance of 2 persons for transfer and toileting. She did not walk. She had 3 stage II ulcers. She was a Hospice resident.</p> <p>An order documented on Resident #B's May 2016 physician's recapitulation orders initiated 4/17/13, indicated to ensure spacers were in place between her 1st and 2nd toe on both feet to separate her toes.</p> <p>A pressure ulcer plan of care for Resident</p>		<p>MD reviewed current order for toe spacers and order dc'd at this time due to improved status of wounds on toes.</p> <p>Others</p> <p>No other residents identified to have order for toe spacers.</p> <p>Education</p> <p>In-service licensed staff on following a physician order and on ensuring nurse management is aware if a product is not available.</p> <p>Monitor</p> <p>DNS/designee to watch dressing change being completed to ensure physician's order and plan of care being followed related to pressure ulcers. These audits to be completed 3 times weekly x 6 0 days, 2 times weekly x 60 days, then weekly x 60 days.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no</p>	

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	<p>#B indicated on 8/28/14, an intervention added was to ensure spacers were in place between her 1st and 2nd toes on both feet to separate her toes.</p> <p>An order documented on Resident #B's May 2016 physician's recapitulation orders initiated 4/14/16, indicated skin prep would be applied to her 1st and 2nd toe and between the 2 toes on her left foot every 3 days. Tegaderm foam would be applied to the 2nd toe. A toe separator would be applied between her 1st and 2nd toe</p> <p>A "Wound Evaluation Flow Sheet" for Resident #B signed 5/18/16, indicated she had a 1.0 centimeter (cm) long by 2.0 cm wide pressure ulcer on her right heel identified in in the facility on 3/14/16.</p> <p>A "Wound Evaluation Flow Sheet" for Resident #B signed 5/20/16, indicated she had a 2.0 cm by long by 1.1 cm wide by 0.1 cm deep pressure ulcer on her left second toe identified in the facility on 4/11/16.</p> <p>A "Wound Evaluation Flow Sheet" for Resident #B signed on 5/20/16, indicated she had a 0.8 cm long by 0.9 cm wide by 0.2 cm deep pressure ulcer on her left great toe identified in the facility on 4/13/16.</p>		trends identified then will review on PRN basis.		

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	<p>On 5/23/16 at 10:50 a.m., the Assistant Director of Nursing (ADON) was observed providing a dressing change to Resident #B's 1st and 2nd toe on her left foot and a treatment to her right heel. The ADON removed Resident #B's sock and soiled dressings from her left foot toes. No toe spacers were visible between her 1st and 2nd toes. The ADON removed her sock from her right foot and no spacers were visible between her 1st and 2nd toes. Her great toe and second toe on both feet were tight up against each other with no space between them. After her treatments and dressing was completed, the ADON placed clean socks on her feet. He had not placed any toe spacers between her toes on either feet.</p> <p>On 5/24/16 at 9:30 a.m., the ADON indicated he had not placed any toe spacers between Resident #B's toes when he provided the treatments and dressing change on 5/23/16, like the physician's order had said to.</p> <p>On 5/24/16 at 10:06 a.m., Resident #B was observed seated in her geriatric chair in her bedroom. Her feet were slightly elevated and were resting in pressure boots on the her geriatric chair foot rest. She was not wearing socks. She did not</p>			

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	<p>have toe spacers between her toes on either feet.</p> <p>On 5/24/16 at 2:25 p.m., Resident #B was observed seated in her geriatric chair in the hallway. Her feet were elevated and resting in pressure boots on her geriatric chair foot rest. She was not wearing socks. She did not have any toe spacers between her toes on either feet.</p> <p>A "Skin Integrity Guideline" provided by the Administrator on 5/25/16 at 11:33 a.m., indicated the following: "Purpose: To provide a comprehensive approach for monitoring skin conditions. To decrease pressure ulcer and/or wound formation by identifying those patients/residents who are at risk, and implementing appropriate interventions. To promote healing of wounds of any etiology, whether admitted or acquired. ...The following elements are in place to demonstrate satisfactory compliance with guideline: ...Visual observation that physical interventions are in place...."</p> <p>3.1-40(a)(2)</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, interview and record review, the facility failed to implement a toileting program for a resident to improve and maintain her bladder function, failed to provide incontinent care to prevent Urinary Tract Infections (UTI) for a resident with a history of UTI's and failed to provide timely incontinent care for 3 of 3 residents who met the criteria for urinary incontinence of 3 residents reviewed (Resident #D, Resident #J and Resident #B).</p> <p>Findings include:</p> <p>1.) Interview with Resident #D on 5/19/16 at 1:31 p.m., indicated she did know when she needed to use the restroom. The resident indicated staff did not have her on a scheduled toileting</p>	F 0315	<p>Res D, J, B</p> <p>FFT-implement a toileting program for a resident to improve and maintain their bladder function, failed to provide incontinent care to prevent Urinary Tract Infections for a resident with a history of UTI's and failed to provide timely incontinent care for 3 of 3 resident reviewed</p> <p>Res Identified</p> <p>Res D reviewed for toileting program and program implemented at this time</p> <p>Others</p> <p>All residents have the potential to be affected. Reviewed all residents with</p>	06/24/2016

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	<p>program.</p> <p>Review of the record of Resident #D on 5/19/16 at 2:32 p.m., indicated the resident's diagnoses included, but were not limited to, cerebral ischemia, UTI (5/14/16), constipation, overactive bladder, dementia without behavioral disturbance, osteoarthritis, and hypertension.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #D, dated 9/24/15, indicated she had the ability to understand others and make herself understood, she was cognitively intact for daily decision making. she required extensive assistance of one person to use the restroom and was frequently incontinent of her bowels and bladder. The resident was not on a toileting program.</p> <p>The Annual MDS assessment for Resident #D, dated 3/22/16, indicated she had the ability to understand others and make herself understood and was cognitively intake for daily decision making. She required extensive assistance of one person to use the restroom. The resident was frequently incontinent of her bowels and bladder and was not on a toileting program.</p>		<p>a diagnosis of UTI and who utilizes a catheter, if appropriate a toileting plan will be implemented. All other residents to be reviewed with MDS schedule and toileting programs to be implemented based on review.</p> <p>Education</p> <p>Nursing staff in-serviced on bowel and bladder tracking tool. Director of Resident Assessment (DORA)/designee to put out tracking tools based on resident's MDS schedule. Tracking tools to be kept in resident's rooms and completed by nursing staff. Once tool completed DORA to pick up tool and review and implement toileting program if warranted based on tracking tool. Nursing staff also in-serviced on providing prompt peri care after incontinent episodes.</p> <p>Monitor</p> <p>Random audits to be completed by DORA/designee on 5 residents/week x 30 days, 3 residents/week x 30 days, 2 residents/week x 30 days, then 1 resident/week x 90 days to audit for completion of tool and implementation of toileting program. DCE/designee to randomly check CNAs performing incontinent care to ensure being provided timely. These audits to be conducted 5 times weekly x 30 days,</p>	

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	<p>The bladder evaluation for Resident #D, dated 5/18/16, indicated the resident was a potential candidate for nursing, restorative/rehabilitation, or bladder training program.</p> <p>The bladder assessment form for Resident #D, dated 12/22/15, indicated the resident's treatment program should be a scheduled toileting/habit training.</p> <p>The bladder evaluation for Resident #D, 12/22/15, indicated the resident was a potential candidate for nursing, restorative/rehabilitation, or bladder training program.</p> <p>Interview with Resident #D's Family member on 5/20/16 at 10:00 a.m., indicated the resident was not on a toileting program and she was suppose to be.</p> <p>Interview with QMA #3 on 5/23/16 at 10:53 a.m., indicated she did not know which residents were on toileting programs. QMA #3 indicated she was caring for Resident #D and showed me Resident #D's profile. The profile only had an area for incontinent or continent.</p> <p>Interview with MDS coordinator #4 on 5/23/16 at 11:38 a.m., indicated she was over the restorative programs. MDS</p>		<p>3 times weekly x 30 days, 2 times weekly x 30 days then weekly x 90 days.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>		

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	<p>coordinator #4 indicated the facility did not currently have any residents on toileting programs. MDS coordinator #4 indicated the reason she did not have residents on toileting programs was because she had not received three day voiding patterns from the nurses. MDS coordinator #4 indicated all restorative programs were put on the residents profile in the care tracker.</p> <p>Interview with Director Of Nursing (DON) on 5/23/16 at 3:00 p.m., indicated the MDS coordiantor should have followed up with the bowel and bladder assessments and initiated a toileting program for residents from those assessments.</p> <p>2. Resident #J's record was reviewed on 5/24/16 at 11:08 a.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, Alzheimer's disease, dementia with behavioral disturbances, protein-calorie malnutrition, nutritional deficiency, osteoporosis, and osteoarthritis.</p> <p>Resident #J's significant change MDS assessment dated 2/17/16, indicated she rarely/never understood others. She was severely impaired in cognitive daily decision making skills. She required extensive assistance of 1 person for bed</p>			

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	<p>mobility, dressing, personal hygiene, and eating. She required extensive assistance of 2 persons for transfer and toileting. She required limited assistance of 2 persons for ambulation in her room. She had no limitations in her range of motion. She was frequently incontinent and was not on a toileting program.</p> <p>An order for Resident #J documented on her May 2016 physician's recapitulation orders initiated 2/25/15, indicated she received 2 cranberry tablets of 250 milligrams each at bedtime related to UTI's.</p> <p>A physician's order for Resident #J dated 5/13/16 at 6:03 p.m., indicated she would receive Rocephin 1 gram intramuscularly 1 time a day for 5 days for a UTI.</p> <p>A plan of care for Resident #J initiated 5/17/16, indicated her focus was "Urinary Tract Infection, potential or actual due to: Urinary Incontinence." Her goal was her UTI would resolve without any complications. Her interventions indicated she would receive medication as ordered. She would be assisted with toileting or incontinence care as needed. She would be encouraged fluids unless contraindicated.</p> <p>An interview with Resident #J's spouse</p>			

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	<p>on 5/17/16 at 2:41 p.m., indicated his wife had a UTI. He indicated his wife usually had her brief changed daily around 9:00 a.m., and then again around 2:00 p.m., to 2:30 p.m. He indicated he was at the facility daily from 10:00 a.m., until 3:00 p.m.</p> <p>On 5/20/16 at 2:01 p.m., Resident #J was observed being toileted. Resident #J's slacks were wet front and back. CNA #15 and Resident #J's spouse assisted Resident #J to ambulate to the toilet. Her soiled brief was removed by CNA #15 and was soaked with urine. Resident #J urinated in the toilet. CNA #15 indicated she had not changed Resident #J's brief since she arrived at work around 10:35 a.m. Resident #J's spouse indicated he arrived at the facility at 10:00 a.m., and his wife's brief had not been changed since he had been there.</p> <p>On 5/20/16 at 2:26 p.m., Resident #J's spouse indicated he did not feel there were enough staff to care for the residents. He was unsure if his wife was on any type of toileting program but he would like her to be toileted every 2 hours. He believed his wife not being toileted often enough contributed to her UTI's. His wife has had several UTI's since she had lived at the facility.</p>			

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	<p>An interview with the Director of Nursing on 5/25/16 at 3:06 p.m., indicated Resident #J was not on a toileting program and believed Resident #J's dementia was to far progressed to participate in a toileting program. Resident #J was toileted after meals per her husbands request.</p> <p>3. Resident #B's record was reviewed on 5/24/16 at 12:18 p.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, dementia without behavioral disturbances, anxiety, nutritional deficiencies, muscle weakness, peripheral vascular disease, disorder of the skin and subcutaneous tissue, and disorder of the kidney and ureter.</p> <p>Resident #B's significant change Minimum Data Set (MDS) assessment dated 4/15/16, indicated she sometimes was understood and she sometimes understood others. She was severely impaired in her cognitive daily decision making skills She required extensive assistance of 1 person for bed mobility, dressing, eating, and personal hygiene. She required extensive assistance of 2 persons for transfer and toileting. She did not walk. She was always incontinent of urine and was not on a</p>			

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	<p>toileting program. She was a Hospice resident.</p> <p>A plan of care for Resident #B initiated 4/2/13, indicated her focus was "Alteration in elimination of bowel and bladder R/T (related to): DX (Diagnoses) of Generalized Constipation; Diverticulitis of Colon; Functional Incontinence; Diuretic Use: HX (History) of UTI's." One of her goals would be to remain free of a UTI. Her interventions included but were not limited to, her being observed for signs of symptoms of a UTI. She would be provided assistance to toilet. Briefs/pads would be used for incontinence protection and to maintain her dignity per Resident #B's request.</p> <p>On 5/23/16 at 11:33 a.m., Resident #B was observed being assisted into bed for incontinence care by CNA #16 and LPN #13 with the use of a Marissa Lift. Resident #B's brief was wet with urine. CNA #16 indicated Resident #B's brief had last been changed when she showered her at 7:30 a.m., that morning.</p> <p>An interview with CNA #16 on 5/23/16 at 11:49 a.m., indicated a resident who was incontinent should be changed approximately every 2 hours. She indicated she believed there were not enough staff to care for the residents</p>			

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	<p>timely and properly, "because you rush, rush, rush." She indicated she did not have enough time to change all her incontinence residents every 2 hours.</p> <p>The "Incontinence Management/Bladder Function Guideline" provided by the Administrator on 5/25/16 at 11:33 a.m., indicated the following: "Purpose: The purpose of a bladder management program is to: Enable the resident to control urination without a catheter whenever possible. Avoid possibility of urinary infection. Prevent skin problems such as pressure areas and excoriation. Improve the morale of the resident. Restore the resident's dignity. Manage urinary incontinence, restore or maintain as much normal bladder function as possible. Procedure: Evaluation 1. Upon admission (if the resident has a history of incontinence) complete a Bowel and Bladder Tracking Tool. Completed to identify any trends or patterns that the resident may have in relation to incontinence. 3 Full days completed (the days do not have to be consecutive). 2. Complete the Bladder Evaluation Form and the Bowel Evaluation Form. Obtaining admission information regarding urinary continence status. Identifying the signs and symptoms of urinary and bowl incontinence. Identification of potentially reversible</p>			

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	<p>(transient) causes of urinary incontinence. This includes conditions, environmental factors and hydration status. Identification of a contributing diagnosis/medical condition. Identification of medications that may be contributing to bladder dysfunction. Continuing evaluation that includes past medical history/lab results, etc. Depiction of the incontinence symptoms that the resident is presenting with: stress, urge, mixed, overflow and functional. Upon completion of this evaluation as well as the Tracking Tool, the toileting/bladder program can be determined. A note to summarize the findings is documented.</p> <p>...Monitoring/Compliance: The following elements are in place for the center to demonstrate satisfactory compliance with the guide: Incontinent residents are assessed per guideline. Evaluation of casual factors determines program initiated. Care plan reflects individualized program. Observation of care provided matches the plan of care."</p> <p>This federal tag relates to Complaint IN00197809.</p> <p>3.1-41(a)(2)</p>			

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F 0323 SS=G Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to prevent a dependent resident from falling forward out of her wheelchair while being propelled by staff, resulting in a head laceration and failed to ensure a resident with a history of falls was assisted with ambulation with the use of a gait belt, for 2 of 2 residents reviewed for accidents. (Resident #B and #137)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 5/24/16 at 12:18 p.m. Her diagnoses documented on her May 2016 physician's recapitulation orders included but were not limited to, dementia without behavioral disturbances, anxiety,</p>	F 0323	<p>Res B</p> <p>Res #137</p> <p>FFT-prevent a dependent resident from falling forward out of her wheelchair while being propelled by staff, resulting in a head laceration and FFTE a resident with a history of falls was assisted with ambulation with the use of a gait belt, for 2 of 2 residents reviewed.</p> <p>Res Identified</p> <p>Fall care plans for Res B and Res #137 reviewed/ revised to reflect current status</p>	06/24/2016

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	<p>nutritional deficiencies, muscle weakness, and peripheral vascular disease.</p> <p>Resident #B's significant change Minimum Data Set (MDS) assessment dated 4/15/16, indicated she sometimes was understood and she sometimes understood others. She was severely impaired in her cognitive daily decision making skills She required extensive assistance of 1 person for bed mobility, dressing, eating, and personal hygiene. She required extensive assistance of 2 persons for transfer and toileting. She did not walk. She was a hospice resident.</p> <p>A "Verification of Investigation" summary and outcome for Resident #B indicated on 3/13/16 at 4:32 p.m., CNA #17 had been propelling Resident #B in her wheelchair in the dining room and Resident #B fell out of her wheelchair onto her face. CNA #17 had notified the nurse. When the nurse entered the room, Resident #B had been observed lying on the floor on her stomach with her face turned to the right side, and there was blood on the floor. She had a laceration to the center of her hairline and bruising to the back of her right hand with an abrasion. She had been sent to a local emergency room due to the severity of</p>		<p>Others</p> <p>All residents identified at risk for falls reviewed to ensure current interventions appropriate and in place. Care plans reviewed and updated as needed to reflect resident's current plan of care.</p> <p>Education</p> <p>Nursing staff in-serviced on falls guidelines and ensuring plans of care being followed. Therapy in-serviced nursing staff on use of gait belts during ambulation for residents who are appropriate for gait belt use. Nurses in-serviced on completing verification of investigation to include what interventions were put in place at time of fall.</p> <p>Monitor</p> <p>DNS/IDT/designee to review falls from previous day at Clinical Start Up 5 times weekly. Verifications of Investigations to be reviewed at this time to ensure appropriate interventions put in place at time of fall. DCE/designee to watch CNAs ambulate residents on restorative ambulation programs to ensure gait belts being utilized. Gait belt audits to be conducted 5 times weekly x 30 days, 3 times weekly x 30 days, 2 times weekly x 30 days then weekly x 90 days.</p>	

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	<p>her injury. The intervention put in place to prevent a reoccurrence was Resident #B would "have two foot pedals on wheelchair at all times during locomotion." The interview summary from CNA #17 indicated indicated "I was moving resident to get another resident into the dining room. I moved her wheelchair and she fell out." The post fall analysis and plan indicated Resident #B had impaired safety awareness/judgement and a history of falls.</p> <p>A "Progress Note" for Resident #B dated 3/14/16 at 3:57 p.m., indicated she had sutures intact to the center of her forehead with no active bleeding and bruising over the top of her right hand onto her fingers from her previous fall.</p> <p>On 5/20/16 at 10:16 a.m., Resident #B was observed seated in her geriatric chair with her feet slightly elevated on the chair foot rest. She had a dark scab approximately the size of a nickel in the middle of her forehead near her hairline. Her son was in her room visiting and he indicated the scab on her forehead was where she fell out of her wheelchair approximately 2 months prior. He was informed by the facility, a staff member had been propelling his mother's wheelchair in the dining room and she</p>		<p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>fell forward out of the chair. She had only had 1 foot rest on her wheelchair.</p> <p>On 5/23/16 at 10:00 a.m., Resident #B's daughter was in visiting her mother. Resident #B's daughter indicated when her mother used to utilize a standard wheelchair most often there were no footrest on her wheelchair and they were often left lying on her mother's bed, or there was only 1 footrest on her wheelchair. When there was 1 footrest on her mother's wheelchair, staff would place 1 of her feet on the footrest and cross the other foot on top of the foot that was on the wheelchair footrest.</p> <p>On 5/23/16 at 1:40 p.m., the DON indicated when she had spoke to CNA #17 about Resident #B's fall from her wheelchair on 3/13/16, CNA #17 indicated she had been propelling Resident #B in the dining room to allow another resident to enter the dining room and Resident #B let her feet touch the floor and she fell out. Resident #B normally only had 1 footrest on her wheelchair because she was encouraged to use her good foot to propel her wheelchair. Resident #B would lift her foot when propelled by staff. The intervention for Resident #B to prevent a reoccurrence was 2 footrest were placed on her wheelchair.</p>			

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	<p>2. Resident #137's record was reviewed on 5/24/16 at 2:43 p.m. His diagnoses documented on his May 2016 physician's recapitulation orders included but were not limited to, dementia without behavioral disturbances, cognitive deficits following cerebrovascular disease, encephalopathy, impulse disorder, peripheral vascular disease, and hypertension.</p> <p>Resident #137's quarterly MDS assessment dated 3/16/16, indicated he was understood and had the ability to understand others. He was severely impaired in his cognitive daily decision making skills. He required limited assistance of 1 person to transfer and walk in his room. He utilized a walker and wheelchair for locomotion. He had 2 or more falls without injury.</p> <p>A "Verification Of Investigation" for Resident #137 indicated on 1/5/16, a CNA had walked past his room and saw him sitting on the floor, leaning against his bed. Resident #137 had stated "I just wanted to get up." Resident #137 had a habit of laying across his bed with his feet in his wheelchair. Staff reminded him frequently it was not a safe position but he disregarded what staff said. An intervention to prevent reoccurrence</p>						

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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	<p>would be to remind him not to recline across his bed with his feet in his wheelchair. Staff would check to make sure his wheelchair brakes were locked.</p> <p>A "Verification of Investigation" for Resident #137 indicated on 1/26/16, he had slid out of his wheelchair onto the floor and laid on his right side. Resident #137 had stated he was trying to go to bed and slid out of bed. He had a history of transferring himself without assistance and a history of falls. An intervention to prevent reoccurrence would be to put him to bed as soon as he was done eating.</p> <p>A "Verification of Investigation" for Resident #137 indicated on 3/31/16, he had been found sitting on his floor next to his bed. Resident #137 stated he had scooted on his butt onto the floor. He had a wet brief and was confused at times. An intervention to prevent reoccurrence would be a mat beside his bed.</p> <p>A plan of care for Resident #137 initiated 5/27/15, indicated his focus was "Ambulation (restorative): Resident is at risk for decline in ambulation r/t (related to) Cerebrovascular Disease." His focus was to ambulate to/from the dining room for meals and to/from the bathroom for toileting 2 times a day for up to 6 days a</p>			

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	<p>week. An intervention was to utilize a gait belt and a 4 wheeled walker for ambulation.</p> <p>An interview with Resident #137's sister on 5/18/16 at 11:48 a.m., indicated Resident #137 had fell 3 or 4 times. She indicated he had fallen approximately a week and a half prior to this date. He had been coming out of the bathroom and fell. "He had a little place on his forehead, elbow, knee, but nothing major."</p> <p>On 5/20/16 at 11:43 a.m., Resident #137 was observed lying on his back in bed. He denied any recent falls "no not really." Resident #137's sister was in his room visiting. She indicated Resident #137 sometimes got up on his own but he really needed assistance. She put his shoes on, assisted him to sit up on the side of the bed, and placed his wheelchair next to his bed and locked the wheels. She held his arm as he stood, pivoted, and sat down in his wheelchair. Resident #137 stated "piece of cake." He was slightly unsteady, leaning to his left after he had his back was facing the wheelchair but was able to correct his stance before sitting down. His sister propelled him to the dining room in his wheelchair.</p>			

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	<p>An interview with Unit Coordinator #6 on 5/20/16 at 1:53 p.m., indicated Resident #137 transferred himself and was unsteady at times. He utilized a wheelchair when he was tired or unsteady and out of his room. He typically didn't ambulate the unit but would ambulate in his bedroom with his rolling walker.</p> <p>On 5/24/16 at 9:43 a.m., Resident #137 was observed seated in a dining chair at the dining table. CNA #18 indicated Resident #137 was on an ambulation restorative program where he walked to his bathroom and from his bedroom to the dining room. He was pretty good at participating in the program. He had a walker in his bedroom that he used. She went to Resident #137's bedroom and returned with his rollator. She locked the wheels on his rollator and he stood independently holding onto the rollator's arms and her holding onto his arm. He ambulated out of the dining room and down the hallway toward his bedroom with short steps and his feet turned outward. His gait was slow and unsteady. CNA #18 pulled his wheelchair behind him with her right hand and held onto his left arm with her left hand. The wheelchair was close to his legs as he ambulated. He stopped in the hallway outside his bedroom and sat down in his wheelchair due to a</p>			

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	<p>medication cart blocked his bedroom door. After the medication cart was moved, CNA #18 locked the left wheel of his wheelchair. He placed his hands on the rollator's arms and attempted to stand but the right side of his wheelchair was moving. After he made several attempts to stand, CNA #18 grabbed the back of his sweat pants with her right hand while holding his left arm with her left hand and assisted him to his feet. She indicated she had forgot to lock the right side of his wheelchair. He ambulated to his bed with CNA #18 pulling his wheelchair behind him with her right hand and holding his left arm with her left hand. He stood from the wheelchair with the wheels unlocked. He was unsteady when he pivoted and sat down on his bed. CNA #18 began to leave his room with his wheelchair next to his bed and the wheels unlocked. When she was queried if his wheelchair brakes should be left in the locked position she stated "sometimes it is and sometimes it's not." Requested his wheelchair brakes be locked in case he decided to get out of bed and into his wheelchair. CNA #18 stated "yeah, I guess he might." When CNA #18 was queried if Resident #137 should wear a gait belt around his waist during assisted ambulation she stated "yes, I forgot to get one this morning."</p>			

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F 0329 SS=D Bldg. 00	<p>3.1-45(a)(2)</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 observation, interview and record review the facility failed to ensure that there was adequate supporting documentation of behaviors for the</p>	F 0329	<p>Res #128</p> <p>FFTE-that there was adequate</p>	06/24/2016	

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	<p>continued use of an antipsychotic medication related to unnecessary medications for 1 of 6 residents reviewed for unnecessary drug use (Resident #128)</p> <p>Findings include:</p> <p>Resident #128 was admitted to the facility on 7/8/15, and was on Risperdal 0.25 mg by mouth twice daily at 9:00 a.m., 1:00 p.m., and Risperdal 0.5 mg at bedtime.</p> <p>On 5/24/16 10:41 a.m., observation of Resident #128 in the hallway sitting in his wheelchair, appears to be asleep, easily awakens then goes back to sleep.</p> <p>Review of Resident #128's record indicated diagnoses included but were not limited to dementia in other diseases classified elsewhere with behavioral disturbances, insomnia, unspecified, other depressive episodes, other specified arthritis, multiple sites, unspecified psychosis not due to substance or known physiological condition, anxiety disorder, unspecified, retention of urine, unspecified enlarged prostate with lower urinary tract symptoms.</p> <p>A review of Resident #128's Minimum Data Set, quarterly assessment dated</p>		<p>supporting documentation of behaviors for the continued use of an antipsychotic medication related to unnecessary medications for 1 of 6 residents reviewed</p> <p>Res Identified</p> <p>MD reviewed use of antipsychotic for Res #128 with recommendation made.</p> <p>Others</p> <p>All residents on antipsychotics reviewed with recommendations made as necessary to ensure current medications continue to be appropriate</p> <p>Education</p> <p>Licensed staff in-serviced on behavior management guidelines. SSD/designee to run behavior report from Care Tracker and review every business day at clinical start up. Behavior meeting held monthly with IDT and psychiatrist to review residents on psychotropics with recommendations made as appropriate. All residents on psychoactive medications to be reviewed by IDT quarterly along with reviewing any behaviors the resident might be displaying and a psychoactive medication quarterly</p>	

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	<p>4/21/16, indicated Resident's cognition was severely impaired, behavior: potential indicators of psychosis, no hallucinations or delusions.</p> <p>11/5/15, a Physician's order to discontinue 1:00 p.m., Risperdal dose.</p> <p>3/18/16, a Physician's order for Risperdal 0.5 mg twice daily, due to failed gradual dose reduction.</p> <p>A review of the Psychiatric Progress Notes dated 4/7/16, indicated Chief Complaint... "12/25/15, the pt (patient) is sitting in the dining room eating. He is pleasant, uses his writing board to communicate. He denies any issues with anxiety, depression or insomnia. His mood is pleasant. January 7, 2016: Patient was seen today in psychiatric followup. He has not complaints, but did state "I'm nuts".</p> <p>3/17/16, The pt is sitting in his seat in the dining room. He is pleasant, requires written communication due to deafness. He reports no symptoms of anxiety or depression. His affect is pleasant, polite.</p> <p>4/7/16, The pt is sitting in the dayroom with peers. His affect is constricted but remains pleasant. He is no longer feeling as anxious per his report. History of Present Illness/Interval History...</p> <p>12/24/15, Staff report the pt is having an</p>		<p>evaluation form to be completed to show if medication continues to be appropriate.</p> <p>Monitor</p> <p>UM/designee to track all residents on antipsychotics to ensure quarterly reviews are being completed. These reviews to be completed based on MDS schedule.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>overall decline. His wife has died in the last couple of weeks. He also has a URI (upper respiratory infection). He is having episodes of yelling out. January 7, 2016: Patient continues to decline both cognitively and physically. He does not really talk about his wife who died last month. I'm not sure if he remembers. He does seem to be somewhat uncomfortable and anxious, but cannot really specify why. He denies particular difficulty with his mood. He noted. He has been on for his upper respiratory tract infection. No recent psychiatric or behavioral issues noted in nursing notes. We did decrease his Risperdal back in November.</p> <p>3/17/16, The pt is showing an increase in anxiety and rumination since GDR (gradual dose reduction) of his Risperdal in 11/15. This has gradually increased to the point it has become intolerable for him. He has underlying delusions that he "needs to be doing something" but not sure what it is. 4/7/16, According to staff the pt is no longer anxious, yelling out or ruminating as he was before. He is quiet and calm.</p> <p>Sources of Information-The patient was a source of information used to complete the history documented in this note. The caregiver, nurse, was a source of information used to complete the history documented in this note. The patient's caregiver, social worker, was a source of</p>			

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	<p>information used to complete the history documented in this note. Assessment - Sources of Risk No evidence of acute risk of harm to self or others..."</p> <p>A review of Resident #128's Resident Behavior Log provided on 5/24/16 at 12:55 p.m., by the Administrator indicated from 7/8/16 through 7/31/15, Resident #128 had 10 episodes of wandering behaviors, no episodes of verbal behavior, no episodes of physical behaviors, no episodes of other behavior and no episodes of rejects care.</p> <p>The behavior log for 8/1/15 through 8/19/15, indicated (no behavior log provided for 8/20/15 to 8/31/15), the Resident had 1 episode of wandering behavior, no episodes of verbal behavior, no episodes of physical behaviors, no episodes of other behavior and no episodes of rejects care.</p> <p>No behavior log was provided for 9/1/15 to 9/16/15, a behavior log dated 9/17/15 through 9/30/15, indicated Resident #128 had 3 episodes of wandering behaviors, 1 episode of verbal behavior, 4 episodes of other behavior and no episodes of rejects care.</p> <p>The behavior log for 10/1/15 through 10/31/15, indicated the Resident had no episodes of wandering behaviors, no episodes of verbal behavior, 8 episodes of other behavior and no episodes of</p>			

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	<p>rejects care.</p> <p>The behavior log for 11/1/15 through 11/30/15, indicated Resident #128 had no episodes of wandering behaviors, no episodes of verbal behavior, 7 episodes of other behavior and no episodes of rejects care.</p> <p>The behavior log for 12/1/15 through 12/31/15, indicated the Resident had 1 episode of wandering behaviors, 5 episodes of verbal behavior, 9 episodes of other behavior and no episodes of rejects care.</p> <p>The behavior log for 1/1/16 through 1/31/16, indicated Resident # 128 had 8 episodes of wandering behaviors, 1 episode of verbal behavior, 8 episodes of other behavior and no episodes of rejects care.</p> <p>The behavior log for 2/1/16 through 2/29/16, indicated the Resident had 7 episodes of wandering behaviors, no episodes of verbal behavior, 4 episodes of other behavior and no episodes of rejects care.</p> <p>The behavior log for 3/1/16 through 3/4/16, indicated the Resident had 7 episodes of wandering behaviors, no episodes of verbal behavior, 4 episodes of other behavior and no episodes of rejects care, no log provided for 3/5/16 to 3/31/16.</p> <p>The behavior log for 4/7/16 through 4/23/16, indicated Resident #128 had 5</p>			

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	<p>episodes of wandering behaviors, no episodes of verbal behavior, no episodes of other behavior and no episodes of rejects care, no behavior log provided for 4/1/16 to 4/6/16 or for 4/24/16 through 4/30/16.</p> <p>The behavior log for 5/10/16 through 5/24/16, indicated the Resident had 5 episodes of wandering behaviors, no episodes of verbal behavior, no episodes of other behavior and no episodes of rejects care, no behavior log provided for 5/1/16 to 5/9/16.</p> <p>A review of a document provided by the Administrator on 5/24/16 at 1:20 p.m., indicated the document had listed types of behaviors that residents exhibit under the other behavior documentation on the Resident Behavior Log. Document indicated "Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)."</p> <p>Review of random Nursing Progress notes dated 8/23/15, 9/10/15, 9/12/15, 9/13/15, 3/7/16, 3/9/16, 3/22/16, 3/24/16, 3/28/16, 4/26/16 or 4/27/16, indicated no behaviors documented for verbal</p>			

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	<p>behavior or other behaviors.</p> <p>Interview with Director of Nursing on 5/24/16 at 2:50 p.m., indicated we have a team meeting and report behavior problems to the Physician on a monthly bases.</p> <p>Interview with the Unit Coordinator #6 on 5/24/16 at 2:55 p.m., indicated if its something significant we report it to the Physician immediately.</p> <p>Care plan dated 7/9/15, revision on 4/22/16, in place for anti-psychotic medication with appropriate focus, goals and interventions.</p> <p>Review of a policy titled Behavior Management Guideline presented by the Administrator on 5/24/16, at 11:15 a.m., indicated "Medication: The use of any medication to control behaviors should always be considered a last resort to assist with managing a patient's/resident's behavior. Antipsychotic drugs should not be used unless the clinical record documents that the patient/resident has one or more of the following "specific conditions", as directed and documented by the Physician:</p> <p>A. Conditions other than Dementia:</p> <ol style="list-style-type: none"> <li>1. Schizophrenia</li> <li>2. Schizo-affective disorder</li> </ol>				

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	<p>3. Delusional disorder</p> <p>4. Mood disorders (e.g. bipolar disorder, severe depression refractory to other therapies and/or with psychotic features)</p> <p>5. Psychosis in absence of dementia</p> <p>6. Medical illnesses with psychotic symptoms (e.g. neoplastic disease or delirium)</p> <p>7. Schizophreniform disorders</p> <p>8. Atypical psychosis</p> <p>9. Tourette's disorder</p> <p>10. Huntington's disease</p> <p>11. Nausea and vomiting associated with cancer or chemotherapy</p> <p>12. Hiccups (not induced by other medications)</p> <p>B. Behavioral or Psychological Symptoms of Dementia (BPSD): Antipsychotic medications in persons with dementia should not be used if only indication is one or more of the following: wandering poor self-care restlessness impaired memory mild anxiety insomnia inattention or indifference to surroundings sadness or crying alone that is not related to depression or other psychiatric disorders fidgeting</p>			

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F 0371 SS=E Bldg. 00	<p>nervousness uncooperativeness (e.g. refusal of or difficulty receiving care)... D. Additional Criteria: Enduring Conditions: Antipsychotic medications may be used to treat an enduring (i.e., non-acute; chronic or prolonged) condition, if the clinical condition/diagnosis meets the criteria in Section B above. In addition, before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior/s must clearly and specifically be identified and documented..."</p> <p>3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(6)</p> <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</p>			

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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-BRANDYWINE	STREET ADDRESS, CITY, STATE, ZIP CODE 745 N SWOPE ST GREENFIELD, IN 46140
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	<p>under sanitary conditions</p> <p>Based on observation, record review, and interview, the facility failed to ensure a range hood above a gas cooking range was free of rust. This had the potential to affect 109 residents who received meals in the facility.</p> <p>Findings include:</p> <p>During an observation, on 5/23/2016 at 2:18 p.m., two areas below and on the back of the range hood were rusted. One area along the upper back right side was rusted in a horizontal strip approximately five inches long by three feet wide. The second area was rusted horizontally across the entire eight foot length along the back of the range hood and was about 5 inches long. The Dietary Manager indicated she did not know how long it has been like that.</p> <p>During an interview, on 5/23/16 at 3:36 p.m., the Executive Director indicated the range hood had last been cleaned by [Name of company] on 4/17/16 and the rust was not there at that time. She provided the work order for the cleaning, and the work order did not indicate any comments about the rusted areas.</p> <p>On 5/25/2016 at 9:33 a.m., the</p>	F 0371	<p>Res</p> <p>FFTE-a range hood above a gas cooking range was free of rust.</p> <p>Res Identified</p> <p>No residents were noted to have been effected. Rust was removed and range was painted.</p> <p>Others</p> <p>All residents have the potential to be effected.</p> <p>Education</p> <p>All staff in-serviced on reporting rusted items to ED/Maintenance/designee.</p> <p>Monitor</p> <p>ED/designee will monitor gas cooking range during monthly kitchen tour.</p> <p>Maintenance Director/designee will monitor other equipment for rust during weekly rounds.</p> <p>QAPI</p>	06/24/2016

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F 0372 SS=F Bldg. 00	<p>Maintenance Director indicated he saw the rusted areas, took pictures, and sent them to the cleaning company. He said it wasn't on the report, it is a galvanized metal and usually doesn't rust. Also, it is on the surface, and with the steam rolling up it wouldn't take any time for it to rust, he got some paint to repair it with, and with the steam coming and hitting it, it could rust more quickly. He said the company uses a chemical to cut through the grease, they clean it with a cleaner, then pressure wash it, and he checked it a couple of days after and it wasn't on there then.</p> <p>3.1-21(i)(3)</p> <p>483.35(i)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY The facility must dispose of garbage and refuse properly.</p> <p>Based on observation and interview, the facility failed to ensure the area around the dumpsters had no debris or large items outside the dumpsters for 1 of 1 observations. This had the potential to</p>	F 0372	<p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p> <p>Res FFTE-the area around the dumpsters had no debris or large items outside the dumpsters for 1 of 1 observations. Res Identified N/A Others Large items around the</p>	06/24/2016

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	<p>affect 109 residents who resided in the facility.</p> <p>Findings include:</p> <p>During an observation, on 5/23/2016 at 2:41 p.m., with the Dietary Manager, the following was observed behind the 2 dumpsters on a concrete area in back of the facility:</p> <ul style="list-style-type: none"> <li>- 1 metal wire, 4 shelf storage rack, with wheels, approximately 5 feet tall by 4 feet wide,</li> <li>- 1 5 gallon bucket setting on the ground,</li> <li>- 1 medium sized blue trash can, upside down on the ground,</li> <li>- 1 large wooden pallet leaning against a fence in back of the dumpsters,</li> <li>- 3 pieces of slightly rounded plastic that were approximately 4 inches wide by 20 feet long, and had dozens of red bugs with black legs crawling on them, lying on the ground in front of the fence, behind the dumpsters,</li> <li>- a small tire with the rim intact, leaning against the fence,</li> <li>- a 'T' shaped bone, on the ground,</li> <li>- a large, 20 milliliter syringe,</li> <li>- a large piece of brown paper, crumpled on the ground, and</li> <li>- a knob with numbers around the edge on the ground.</li> </ul>		<p>dumpster removed on 5/27/16.</p> <p>Education All staff will be in-serviced on keeping the areas around the dumpsters free of debris and large items.</p> <p>Monitor Maintenance Director/Maintenance Assistant/designess to check around dumpsters daily to ensure the area is free of debris or large items.</p> <p>QAPI Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>The Dietary Manager indicated, at that time, the metal rack has been by the dumpster for about 2 weeks.</p> <p>On 5/23/16, at 2:43 p.m., Maintenance Director #9 indicated they have been putting a few pieces in the large dumpster each week, but they can't put too much in because it will fill up the dumpster. He said the dumpsters are emptied on Monday, Wednesday, and Friday, and if they get full they will call and have them come out and empty them again.</p> <p>On 5/24/2016, at 4:01 p.m., the Executive Director indicated that maintenance is responsible for keeping the parking lot and other areas clean. She said they had ordered new equipment for the kitchen, and they couldn't fit everything in the dumpster, and that is why it is currently out there and said they would have to have someone pick them up.</p> <p>3.1-21(i)(5)</p>			

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F 0441 SS=E Bldg. 00	<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 accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>A. Based on record review and</p>	F 0441		06/24/2016			

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	<p>interview, the facility failed to ensure the "Infection Surveillance Data Collection Forms" were completed as part of the infection control program to accurately maintain a record of infections. This had the potential to affect all 109 residents in the facility.</p> <p>B. Based on observation and interview, the facility failed to ensure staff were using proper hand hygiene during mealtime for 2 of 2 dining observations.</p> <p>Findings include:</p> <p>A. On 5/24/16 at 3:53 p.m., the infection control logs and "Infection Surveillance Data Collection Forms" for March 2016 and April 2016 were provided by the Executive Director.</p> <p>The March 2016 "Infection Surveillance Data Collection Forms" were incomplete, for 8 of the 18 residents with infections, in the areas of results of the culture, interventions: reinforce handwashing, education, special cleaning procedure, or resident assigned equipment. The forms were incomplete for 5 of the 18 residents if a culture had been done.</p> <p>The April 2016 "Infection Surveillance Data Collection Forms" were incomplete, for 4 of 13 residents for the results of the</p>		<p>Res</p> <p>FFTE-the "Infection Surveillance Data Collection Forms" were completed as part of the infection control program to accurately maintain a record of infections.</p> <p>Res Identified</p> <p>All residents have the potential to be affected. Licensed staff in-serviced on infection control guidelines.</p> <p>Others</p> <p>All residents have the potential to be affected. Licensed staff in-serviced on infection control guidelines.</p> <p>Education</p> <p>Licensed nurse in-serviced on how to complete infection surveillance data collection forms. ADNS/DCE/designee to review data collection forms for completeness and utilize information from these forms to complete monthly infection control log.</p> <p>Monitor</p> <p>ADNS/DCE/designee to review orders every business day to track for new ATB orders.</p>	

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	<p>culture, and interventions of reinforce handwashing, education, special cleaning procedure or resident assigned equipment.</p> <p>The Assistant Director of Nursing (ADoN) was interviewed on 5/25/2016 at 10:20 a.m. He indicated there are two ways to track infections and the causative agent. When a urinalysis and culture and sensitivity is done, the nurses on the floor, and unit coordinator track the labs, and also the lab sends a monthly report with all the culture and sensitivity results they have done for the previous month. He said the lab sends the report right at the end of the month and that's when they usually get those reports.</p> <p>The ADoN indicated they take the data and plug it into their monthly Quality Assurance meeting and discuss the urinary tract infections, to prevent and treat based on certain criteria. They use this to analyze data such as culture and sensitivity from their surveillance logs to identify a cluster or outbreak. He indicated he is in charge of that, and he is working on a protocol.</p> <p>The ADoN also indicated the surveillance form is filled out by the floor nurse, and turned in after the culture is completed. The culture information</p>		<p>ADNS/DCE/designee to then audit the infection surveillance data collection forms to ensure one was initiated for each new ATB order. These audits to be completed 5 times weekly x 30 days, 3 times weekly x 30 days, 2 times weekly x 30 days, then 1 time weekly x 30 days.</p> <p>QAPI</p> <p>Results of these audits will be taken to QAPI x 6 months to track for any trends. If any trends are identified the audits will be completed based on QAPI recommendations. If no trends identified then will review on PRN basis.</p>	

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	<p>should be on the lab in the patient's chart, and didn't know if there was anywhere else the information is located. Then the form is turned in to him, and the form is supposed to be complete with all the information in the bottom section completed, and he isn't sure why it wasn't done.</p> <p>A policy for "CMS Investigative Protocol for Infection Control" was provided on 5/25/16 at 4:00 p.m. by the Executive Director, The policy indicated, but was not limited to, "Objectives: To determine if the facility has an infection prevention and control program that prevents, investigates, and controls infections in the facility, and determines appropriate procedures to be applied to a resident with an infection; To determine if the facility has a program that collects information regarding infections acquired in the facility, analyzes the information and develops a plan of action to prevent further infections; To determine if staff practices are consistent with current infection control principles and prevent cross-contamination (e.g., laundry and hand hygiene practices)...."</p> <p>B. An observation of resident dining was conducted on 5/17/16 at 1:00 p.m., in dining room #3 on the AACU unit. CNA #18 was standing between 2 resident's assisting both residents with their meal.</p>						

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	<p>As CNA #18 was assisting both residents she periodically rubbed the resident's chin with her hand seated on her right side while encouraging her to swallow. Then CNA #18 periodically fed the resident on her left. CNA #18 had walked away from the dining table and the ACD Director entered the dining room and began assisting the resident that was seated on CNA #18's right side. Then the ACD Director walked over and sat down at another table and began feeding another resident without cleansing her hands. CNA #18 re-entered the dining room and began feeding the resident seated on her right again. She periodically rubbed the residents chin with her hand while encouraging her to swallow. Then she would feed the resident on her left side. CNA #18 was not observed to cleanse her hands during this dining observation.</p> <p>An observation of resident dining was conducted on 5/20/16 at 1:01 p.m., in dining room #3 on the AACU unit. CNA #15 was observed assisting 4 resident seated at one table with their meals. She was walking around the table picking up the residents utensils and giving them a bite of their food and encouraging them to eat. She was touching the residents backs and wheelchairs as she made her way around the table. She picked up one</p>			

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F 9999	<p>of the resident's sandwich and gave her a bite. She walked over to another table and touched 2 resident's drinks and encouraged them to eat and drink. CNA #15 was not observed to cleanse her hands during this dining observation. At 1:13 p.m., CNA #15 walked a resident out of the dining room while holding the residents hand. CNA #15 returned to the dining room at 1:15 p.m., and was not observed to cleanse her hands before she began feeding a resident.</p> <p>An interview with Unit Coordinator #6 on 5/20/16 at 1:30 p.m., indicated she had 32 residents on the AACU unit and 13 of those residents required being fed and 6 residents required prompts and cues.</p> <p>3.1-18(b)(1)(A) 3.1-18(b)(3) 3.1-18(l)</p>			

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Bldg. 00	<p>3.1-14 PERSONNEL</p> <p>(u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for persons assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure employees had 3 hours of annual dementia specific training, for 4 of 10 employees reviewed. (Employees #1, 2, 8, and 9)</p> <p>Findings include:</p> <p>Employee records were reviewed on 5/25/16 at 10:30 a.m.</p>	F 9999	<p>Personnel</p> <ul style="list-style-type: none"> <li>Employee files lacked the 3 hours of annual dementia training for Employees #1, 2, 8 and 9</li> </ul> <p>Emp Identified</p> <p>Identified staff to complete required training</p> <p>Others</p> <p>All other staff reviewed to ensure dementia training present. Anyone identified as missing training has completed required hours of training</p> <p>Education</p> <p>DNS/Designee to complete annual dementia training with staff. New hire employees will NOT start in staffing until 6hr dementia training is completed.</p> <p>Monitor</p>	06/24/2016
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	<p>Employee #1's hire date was 5/21/13. Training records indicated this employee had 1 hour of dementia training in the past year. There was no record of this employee completing 2 additional hours of dementia training in the previous year.</p> <p>Employee #2's hire date was 11/24/14. There was no record of this employee completing 3 hours of dementia training in the previous year.</p> <p>Employee #8's hire date was 11/18/14. There was no record of this employee completing 3 hours of dementia training in the previous year.</p> <p>Employee #9's hire date was 9/18/12. There was no record of this employee completing 3 hours of dementia training in the previous year.</p> <p>During an interview, on 5/25/16 at 6:01 p.m., the Executive Director indicated these 4 employees did not have 3 hours of annual dementia training.</p> <p>3.1-14(u)</p>		<p>Will utilize staff roster and check names off as dementia training completed</p> <p>QAPI</p> <p>Will report findings monthly at QAPI meetings x 6 months. The QAPI committee will evaluate compliance with F9999</p>		