

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00144126.</p> <p>Complaint IN00144126- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: February 27 to March 6, 2014</p> <p>Facility number: 000031 Provider number: 155076 AIM number: 100266150</p> <p>Survey Team: Beth Walsh, RN-TC Courtney Mujic, RN (2/27/14, 2/28/14, 3/3/14, 3/4/14, 3/5/14) Karina Gates, Generalist Tom Stauss, RN (2/28/14, 3/3/14, 3/4/14, 3/5/14, 3/6/14)</p> <p>Census Bed Type: SNF/NF: 116 Total: 116</p> <p>Census Payor Type: Medicare: 14 Medicaid: 84 Other: 18 Total: 116</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 13, 2014, by Janelyn Kulik, RN.</p>	F000000		

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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F000164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, interview, and record review, the facility failed to provide privacy to a resident while they were using a bedpan during a random observation and the the facility also failed to maintain a resident's privacy during a therapy evaluation. This affected 1 of 3 residents reviewed of 3 residents who met the criteria and 1 of 1</p>	F000164	<p>F164</p> <p>It is the practice of this facility that residents have the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>What corrective actions will be accomplished for those</p>	04/05/2014

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	<p>resident's random observation for privacy. (Resident #178 & #181)</p> <p>Findings include:</p> <p>1. During a random observation, on 2/27/14 at 3:20 p.m., Resident #178 put on their call light. CNA #17 went into Resident #178's room and asked what Resident #178 needed. Resident #178 indicated they needed to go to the bathroom. CNA #17 indicated he would put Resident #178 on a bedpan.</p> <p>At 3:26 p.m. on 2/27/14, Resident #178 was observed on a bedpan with their gown pulled up, without any covers over them and no side curtain pulled. Resident #178's roommate was in the room and was able to view Resident #178 on the bedpan.</p> <p>During an interview with the Administrator, on 3/3/14 at 9:42 a.m., he indicated staff were provide privacy when Residents used the bathroom/bedpan.</p> <p>A policy titled, Resident Rights Guidelines with no dated noted, was received from the Director of Nursing, on 3/3/14 at 10:28 a.m. It indicated, "...Screen the resident for privacy...."</p> <p>2. The clinical record for Resident #181 was reviewed on 3/3/14 at 2:00 p.m. The diagnoses for Resident #181 included, but were not limited to, dementia.</p> <p>During an observation on 2/28/14 at 11:03 a.m. of the sitting room on the Alzheimer's Care Unit, Resident #181 was observed receiving a therapy evaluation by Speech Therapist (ST) #15 in front of 16 other</p>		<p>residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #181 was provided privacy for continuing speech therapy. Resident #178 was provided privacy on subsequent use of bedpan.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents have the potential to be affected by the deficient practice. There were no adverse outcomes related to the deficient practice.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>All staff will be re-in-serviced on residents' rights regarding privacy.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p>	

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	<p>residents. ST #15 was heard saying to Resident #181, "It's not your fault. Sometimes you just can't remember things." This was overheard from across the room.</p> <p>An interview was conducted with ST #15 on 2/28/14 at 11:13 a.m. regarding the purpose of her conversation with Resident #181. She stated, "I was evaluating her for speech therapy." Regarding her evaluation taking place in front of other residents, she stated, "I usually evaluate wherever they are. I didn't feel comfortable walking with her, so I didn't evaluate her in the game room like I usually do." Whether she asked staff for assistance to transfer Resident #181 to the game room so the evaluation could be done with privacy, she stated, "No, I didn't ask anyone to transfer her down there. It was just easier to talk to her back there."</p> <p>ST #15 provided a copy of the therapy evaluation tool used in the above observation for Resident #181 on 2/28/14 at 11:30 a.m. It indicated the question, "What day of the week is it?" It indicated Resident #181 answered Saturday. The actual day was Friday. It indicated the question, "What is the year?" It indicated Resident #181 answered 2004. The actual year was 2014.</p> <p>The Residents' Rights policy was provided by the DON (Director of Nursing) on 3/3/14 at 10:47 a.m. It indicated, "Personal Privacy...The social services staff will take an active role in training employees and monitoring practices on issues regarding residents' personal privacy including:...Not discussing resident care, treatment, or personal issues around others."</p> <p>3.1-3(o)(2)</p>		<p>The Director of Nursing Services, Director of Clinical Education, and the Social Services staff will observe residents at the start of care and during care to ensure privacy is being provided, 5 times per week x 4 weeks, 3 times per week x 4 weeks, and 2 times per week x 4 weeks, then monthly. Findings of the observations will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>	

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F000174 SS=D	<p>3.1-3(o)(4) 483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</p> <p>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents had access to a telephone in a private location so conversations would not be overheard for 2 of 4 residents reviewed for privacy. (Resident #10, Resident #67)</p> <p>Findings include:</p> <p>1. Resident #10's clinical record was reviewed on 3/5/2014 at 9:45 am. The Resident's diagnoses included but were not limited to, renal (kidney) failure, dementia, and diabetes.</p> <p>Resident #10's MDS (Minimum Data Set) assessment, dated 12/25/2013, indicated a BIMS (Brief Interview for Mental Status) score of 9. The BIMS score ranges from 0 to 15, with a score of 15 indicative of no cognitive deficit.</p> <p>An interview with Resident #10, on 2/28/2014 at 11:43 am, indicated she did not have privacy when on the telephone.</p> <p>2. Resident #67's clinical record was reviewed on 3/5/2014 at 9:25 am. The Resident's diagnoses included but were not limited to, depression, chronic kidney disease, glaucoma.</p>	F000174	<p>F174</p> <p>It is the practice of this facility that residents have the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #10 and resident #67 were given access to private locations during telephone calls.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents have the potential to be affected by the deficient practice. There were no adverse outcomes related to the deficient practice.</p> <p>What measures will be put into place and the systemic</p>	

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	<p>Resident #67's MDS (Minimum Data Set) Assessment, dated 11/19/2013, indicated a BIMS score of 11. The BIMS score ranges from 0 to 15, with a score of 15 indicative of no cognitive deficit.</p> <p>An interview with Resident #67, on 3/3/2014 at 10:24 am indicated he did not have privacy when on the telephone. Resident #67 indicated, "the only phone we can use is in the middle of the hallway."</p> <p>An observation, on 3/3/14 at 11:20 am, indicated the telephone was not cordless. The telephone was located on the 200 hallway, approximately 1/2 way down the hall between rooms 207 and 209. The telephone was sitting on a table in a closet with no door attached.</p> <p>An interview with the Administrator, on 3/4/2014 at 10:22 am, indicated the phone observed on the 200 hallway was usually available to residents. Also, residents can always request to use a phone in anyone's office, so they have privacy. The Administrator also indicated he was unsure about when residents are informed about telephone usage.</p> <p>3.1-3(f)</p>		<p>changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>A door will be installed on the east hall resident telephone room to provide privacy for telephone calls. A resident telephone privacy policy will be implemented. Upon admission, all residents will receive a copy of the resident telephone policy. All current residents will receive a copy of the resident telephone policy. The resident telephone privacy policy will be routinely discussed at the resident council meetings. All staff will be in-serviced concerning the resident telephone privacy policy.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Director of Nursing Services and the Social Services staff will audit alert and oriented residents using the telephone to ensure residents know where and how to have a private telephone conversation, weekly x 8 weeks, then monthly. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p>		

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F000223 SS=A	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>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 interview and record review, the facility failed to ensure a resident was free from verbal abuse from a CNA after the resident was incontinent. This affected 1 of 15 residents reviewed for abuse. (Resident #176)</p> <p>Findings include:</p> <p>The clinical record for Resident #176 was reviewed 2/28/14 at 11:45 a.m. The diagnoses for Resident #176 included, but were not limited to, dysphagia, blindness, and psychosis.</p> <p>During an interview, on 2/28/14 at 11:12 a.m., Resident #176 was asked, "If staff here (the facility) abused you-this includes verbal, physical or sexual abuse." Resident #176 indicated "yes." Resident #176 further indicated a male staff member, "jumped all over me," last night (2/27/14) for "peeing" my pants. Resident #176 indicated "jumping all</p>	F000223	<p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p> <p>F223</p> <p>It is the practice of this facility that residents have the right to be free from verbal, sexual, physical, and mental abuse, corporate punishment, and involuntary seclusion.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>The verbal abuse incident involving resident #176 was reported to the ISDH. CNA #17 was suspended pending investigation. Investigation determined that the allegation of verbal abuse was substantiated. Employment of CNA #17 was terminated.</p>	

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	<p>over me" meant being verbally aggressive/disparaging. Resident #176 did not indicate exact quotes or phrases, but kept indicating the comments from the male staff member were upsetting.</p> <p>A review of Resident #176 Admission MDS (Minimum Data Set) Assessment, dated 2/20/14, indicated a BIMS (Brief Interview of Mental Status) of 13, which was indicative of no cognitive impairment.</p> <p>The above information was reported to the Administrator. The Administrator indicated, during an interview on 2/28/14 at 1:30 p.m., an investigation would be initiated.</p> <p>A review of the Daily Staffing Schedule, for 2/27/14, indicated only one male working on Resident #176's unit during evening shift, CNA #17.</p> <p>A document titled, Resident (Name of Resident #176) Allegation of Abuse, was received from the Administrator, on 3/6/14 at 10:40 a.m. It indicated, "Resident (Name of Resident #176 in bold face type)- At 8 or 9 pm, male aide [sic] 'got onto me about peeing my pants,' Aide yelled at me, 'You just pulled it out and pee'd [sic] all over yourself.' I said, 'I'm going to report you.' Only male CNA/staff on evening shift and (Name of Unit) [sic] was (Name of CNA #17)...(Name of CNA #17 in bold face type), Evening Shift-'At 10 pm, I was getting ready to leave facility [sic], and the resident was yelling real loud. (Gender of Resident #176) didn't want anything in particular. I handed (gender of Resident #176) call-light and asked him to stop yelling. Resident said, 'I'm going to report you.' When asked about the resident being incontinent and changing [sic] resident's bed,</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents have the potential to be affected by the deficient practice. Residents on the same unit as resident #176 were interviewed. There were no adverse outcomes related to the deficient practice.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>All staff were re-in-serviced on prevention and reporting of resident abuse and the Elder Justice Act.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Executive Director will audit staff weekly x 1 month, every 2 weeks x 1 month, and monthly ongoing for knowledge of prevention and reporting of resident abuse and of the Elder Justice Act. The Executive</p>	

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F000241 SS=D	<p>CNA stated that at about 8 pm, he changed resident's bed because 'he had pee'd [sic] over his brief,' but there was no issue with the bed change."</p> <p>A review of the "Report of Incident," dated 3/4/14, indicated, "Brief Description of Incident: ...CNA was verbally abusive with resident due to resident's incontinence....Follow-up: Resident has been confused at times since admission to facility, but his account of the allegation has been consistent over the past five days....Allegation against CNA substantiated. Employment of CNA terminated...."</p> <p>On 3/4/14, at 12:07 p.m., the Administrator indicated CNA #17 was terminated because the allegation of verbal abuse was substantiated.</p> <p>At 3:05 p.m., on 3/6/14, the Administrator indicated again CNA #17 was terminated because the allegation of verbal abuse was substantiated.</p> <p>3.1-27(b) 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to dress a resident according to their preference and failed to ensure 2 residents had clothing that was not labeled with their names exposed. This</p>	F000241	<p>Director will audit residents weekly x 1 month, every 2 weeks x 1 month, and monthly ongoing to identify incidents of residents abuse. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p> <p>F241</p> <p>It is the practice of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in</p>	

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	<p>affected 3 of 4 residents reviewed for dignity. (Resident #176, #21 & #131)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #176 was reviewed 2/28/14 at 11:45 a.m. The diagnoses for Resident #176 included, but were not limited to, dysphagia, blindness, and psychosis. Resident #176's admission date was 2/13/14.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 2/20/14, indicated Resident #176 had a BIMS (Brief Interview of Mental Status) of 13, which was indicative of cognitively intact.</p> <p>During an interview with Resident #176, on 2/28/14 at 11:22 a.m., the Resident indicated they did not want to wear what they had on and it was the only clothing available to them. The Resident was observed to be in a hospital gown. Resident #176 also indicated no one had asked what they would like to wear or if they had any clothes to wear.</p> <p>During the following observations, Resident #176 was wearing a hospital gown: 2/28/14 at 1:55 p.m., 3/3/14 at 2:00 p.m., & 3/3/14 at 2:30 p.m.</p> <p>On 3/3/14 at 2:30 p.m., Resident #176 indicated they still don't have any other clothing and no one had asked if they would like to wear everyday clothes instead of a hospital gown. The Resident further indicated they would prefer to wear everyday clothes. Resident #176 then indicated to look in their closet and drawer. No clothing was observed in the Resident's room.</p>		<p>full recognition of his or her individuality.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #131 and resident #21 were given new white socks without name in large black, block letters. Resident #176 was provided with clothing.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents audited for clothing in closet. All residents audited for names exposed on clothing. No adverse reaction from deficient practice.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>Label maker purchased and clothing to be labeled by staff as needed. Residents' guardian angels will assess need for clothing for their residents and discuss any residents that does</p>	

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	<p>At 2:38 p.m., on 3/3/14, the Social Services Director indicated Residents should be dressed in their preference for clothing.</p> <p>A policy titled, Residents' Rights, dated 10/09, was received from the Director of Nursing on 3/3/14 at 10:28 a.m. It indicated, "...the social services staff will promote the following types of staff interactions with residents, which maintain their dignity...assisting with the purchase of personal clothing that is clean, in good repair,...and appropriate to time of day and individual preferences...."</p> <p>2. Resident #21's clinical record was reviewed on 3/4/2014 at 9:30 am. The Resident's diagnoses included but were not limited to, dementia, depression, severe malnutrition, anemia, diabetes, anxiety.</p> <p>An observation of Resident #21, on 2/28/2014 at 2:07 pm, indicated he was sitting in his wheelchair with no foot pedals attached, with his feet on ground, and he had on regular socks with no shoes.</p> <p>An observation of Resident #21, on 3/4/2014 at 9:48 am, indicated he was participating in a ball toss activity in the activity room. He was seated in his w/c, had on socks, and his feet were resting on the floor. He had no shoes on. His socks were labeled with his last name in large letters, written in black marker.</p> <p>An observation of Resident #21, on 3/4/2014 at 12:23 pm, indicated he was seated in his wheelchair in the dining room eating lunch. He had on socks and his feet were resting on the floor. He had no shoes on. His socks</p>		<p>not have appropriate clothing in daily morning meeting with leadership team.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Director of Nursing Services, Assistant Director of Nursing Services, and Social Services staff will observe daily personal clothing items to ensure no large labeled names are visible on clothing, and will review resident guardian angel room round sheets weekly x 8 weeks, then monthly to ensure proper clothing. Findings of the observations and reviews will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>	

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	<p>were labeled with his last name in large letters, written in black marker. At 2:30 pm, he was sitting in his wheelchair across from nursing station and he was wearing socks labeled with his last name and no shoes.</p> <p>A care plan, dated 9/23/2011, indicated, "Focus: I have a physical functioning deficit r/t self care impairment, mobility impairment. Interventions: Dressing assistance."</p> <p>An interview with CNA #2, on 3/5/2014 at 10:34 am, indicated he doesn't wear shoes because he has a bunion on one of his feet, so it would hurt his foot if he wore shoes. CNA #2 indicated, "(The resident's) wife told me not to put shoes on him because of the bunion."</p> <p>3. The clinical record for Resident #131 was reviewed on 3/4/14 at 1:00 p.m. The diagnoses for Resident #131 included, but were not limited to, dementia.</p> <p>An observation of Resident #131 sitting on the side of her bed was made on 2/28/14 at 1:24 p.m. She was wearing a pair of white socks that went up to her shin. Each sock had her name printed on them in big, black, block letters with permanent marker.</p> <p>An observation of Resident #131 sitting in a chair in the sitting room was made on 3/4/14 at 1:46 p.m. She was wearing a pair of white socks that went up to her shin. Each sock had her name printed on them in big, black, block letters with permanent marker.</p> <p>An interview was conducted with the Alzheimer's Care Unit Coordinator on 3/4/14 at 2:27 p.m. regarding visible labeling of</p>			

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F000248 SS=D	<p>residents' clothing. She indicated, "We label with permanent marker on socks. We've always done that. I don't know of any other way to do it. We ask families to mark the clothes, and sometimes we do it. We don't ask the family to label small and in an inconspicuous place. I haven't had any conversations like that with them...I haven't asked family to label inconspicuously, because I haven't noticed it as an issue."</p> <p>3.1-3(t) 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview and record review the facility failed to provide an appropriate, effective activity program on the dementia unit for 2 of 3 residents reviewed of 11 who met the criteria for activities for cognitively impaired residents. (Resident #96 and #27) The facility also failed to ensure adequate activities and social program participation for a resident confined to bed. This affected 1 of 1 residents reviewed of 3 who met the criteria for PASRR (Preadmission Screening and Resident Review). (Resident #25)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #96 was reviewed on 2/28/14 at 1:30 p.m. The diagnoses for Resident #96 included, but</p>	F000248	<p>F248</p> <p>It is the practice of this facility to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #96 and resident #27 provided and participated in activities. Resident #25 was discontinued from bed rest and</p>	

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	<p>were not limited to, Alzheimer's dementia.</p> <p>An observation was made on 2/28/14 at 1:32 p.m. of Resident #96 sitting in the sitting room of the Alzheimer's Care Unit (ACU), staring around the room . She was not watching television, listening to music, having a conversation or engaging in any sort of activity. Seven other residents were present, but no staff were present in the room.</p> <p>The February Activity Calendar for Group B, the group in which Resident #96 is assigned, indicated a total of 3 activities for the day of 2/28/14. They were Spiritual Reflections, Mind Stretch and Jokes/Readings. No times were scheduled for these activities.</p> <p>An interview was conducted on 2/28/14 at 3:07 p.m. with the nurse on duty, LPN #10, regarding scheduled activities for the day. She indicated the CNA's were responsible for activities, and it had been that way since last year. She stated, "We need both CNAs to do the ADLs (activities of daily living) and stuff, so there's not necessarily enough staff. It's not realistic for 1 CNA to be doing activities. We need 3 CNAs, not 2. We have 26 residents." She indicated she did not see Spiritual Reflections or Jokes/Reading done that day. She indicated she saw Mind Stretch which was "questions about their past more or less" with 6 or 7 residents with CNA (Certified Nursing Assistant) #16 after lunch.</p> <p>A second observation was made on 3/4/14 at 1:43 p.m. of Resident #96 sitting, staring in the sitting room of the Alzheimer's Care Unit (ACU). She was not watching television, listening to music, having a conversation or engaging in any sort of activity.</p>		<p>taken to activities.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All Alzheimer's Care Unit residents have the potential to be affected by the deficient practice. There were no adverse outcomes related to deficient practice.</p> <p>Audit of all residents on bed rest or isolation conducted and activities implemented.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>Alzheimer's Care Unit staffing to be increased and maintained with three CNA's on day shift. Activities training to be implemented with Alzheimer's Care Unit staff.</p> <p>All residents on bed rest or isolation will be provided activities designed to meet their interests and their physical, mental, and psychosocial well-being at least 30 minutes per week.</p> <p>How the corrective actions will</p>	

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	<p>On 3/4/14 at 2:17 p.m. and 2:48 p.m., Resident #96 was observed sitting in the same spot, still just sitting.</p> <p>An interview was conducted with CNA #12 on 3/4/14 at 1:49 p.m. regarding the activity program on the ACU. She indicated only 2 CNA's are scheduled per shift. She stated she and CNA #13 were the 2 CNAs currently on duty. She stated, "It's normally just 2 of us, a nurse and the Unit Coordinator. Today I did an activity of manicures about 10:30 (a.m.). I painted 6 residents' nails. (Name of Resident #96) didn't want hers done. I worked from 6-2 (p.m.) today. I work down here maybe once a week, day shift. I have never been assigned to just do activities consistently. I have never seen a consistent activity program down here. There's plenty of down time here...When I'm here, I'll do an activity once between 9:30 and 10:30 (a.m.). This unit is consistent (sic) taking residents to the restroom, so it would not be reasonable for me to conduct a consistent activity program." She indicated no one had ever discussed with her what activities were appropriate for residents with Alzheimer's dementia. She stated, "Some residents were not interested in the manicure at all. I've seen in other facilities where an Alzheimer's unit has it's own activity program, and that works better. I wouldn't really know how to do certain activities with them. It would be a good idea to have someone down here who's trained to do activities with people who have Alzheimer's."</p> <p>An interview was conducted with CNA #13 on 3/4/14 at 2:14 p.m. regarding the activity program. She stated, "I have not done an activity with them today, but (name of CNA #12) did nails. I haven't had time to do an</p>		<p>be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Alzheimer's Care Director, Director of Nursing Services, Social Services staff, and Activities Director will audit Alzheimer's Care Unit activities, as well as activities for residents on bed rest or isolation weekly x 4 weeks, and monthly thereafter. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>	

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	<p>activity, because I've been providing care. I could probably do 15 minutes per shift of activity time, and the other aide could do 15 minutes for a total of 30 minutes from about 6:00 (a.m.) to 2:00 (p.m.). We did activities on a regular basis when we had 3 CNA's back here. We stopped having the 3rd CNA maybe 6 months ago. Since then, the 2 CNA's who are back here only have time to do ADL stuff. I get here at 6 (a.m.), start showers, strip the beds, go around and do ADL's on non showers (residents not getting a shower that day), get residents to the dining room for breakfast by 8:00 (a.m.), then assist with dining at breakfast, then clean up. By now it's 9:30 or 10:00 (a.m.) and we pass snacks in the sitting/TV room. That's when, maybe, we can do an activity. About 10:30 (a.m.), I take a break until 11:00 (a.m.). I set up for lunch, do care tracker (CNA database), then bring residents to the dining room about 11:45, lunch at 12:00 (p.m.), then assist with dining until 1:30 (p.m.), then we're doing care tracker stuff like bowel and bladder, consumption. Oh, and we take out the trash. Then, I'm off at 2:00 (p.m.). When we had 3 CNA's down here, it was a lot easier with the extra help. One could do activities; one could do care tracker; one could do ADLs and we could rotate. There was always something going on with activities. The care (level of care) has also increased so we do the care, but basically, what had to be eliminated was spending time with the residents. We don't do that as much." She also indicated, "No one has ever given me training on specific activities for residents with Alzheimer's dementia."</p> <p>An interview was conducted with the Alzheimer's Care Unit Coordinator on 3/4/14 at 2:48 p.m. regarding the activity program.</p>			

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	<p>She indicated, "I am in charge of planning activities. CNAs are responsible for implementing it. We have things set up, but not as blocked time, because things change back here. It is our goal to do the activities on the schedule, but they vary...We don't have scheduled activities. There is not a scheduled activity right now." Regarding activities for Resident #96, she indicated, "Activities are set up to do things she likes to do like music...No, she hasn't done any music today. She likes chair exercises. No, it wasn't done today." At this time the activity care plan for Resident #96 was reviewed with the ACU Coordinator. It indicated an intervention was, "I enjoy coloring. Please make sure I have crayons and pages available." Regarding whether Resident #96 had crayons and pages available, the ACU Coordinator indicated, "When we do arts and crafts, we pull them out because it is supervised." Regarding whether the CNA's on the unit had any type of training for activities, she indicated, "The CNA's have annual dementia training, but nothing specific to recreational activities for Alzheimer's residents. I'm not sure if anyone has thought about that. I haven't. I don't have a recreational therapy background. We have not supplied recreational activity training back here. There's no way for us to have a nonstop activity program back here. We'd need another staff member. The CNA's can't do ADLs and activities at the same time."</p> <p>A final observation was made on 3/6/14 at 10:34 a.m. of Resident #96 sitting in the sitting room in a chair with her eyes closed, not watching TV or doing anything.</p> <p>2. The clinical record for Resident #27 was reviewed on 2/28/14 at 1:35 p.m. The</p>			

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	<p>diagnoses for Resident #96 included, but were not limited to, Alzheimer's dementia.</p> <p>An observation was made on 2/28/14 at 1:32 p.m. of Resident #27 sitting in the sitting room of the Alzheimer's Care Unit (ACU), staring around the room. She was not watching television, listening to music, having a conversation or engaging in any sort of activity. Seven other residents were present, but no staff were present in the room.</p> <p>The February Activity Calendar for Group B, the group in which Resident #27 is assigned, indicated a total of 3 activities for the day. They were Spiritual Reflections, Mind Stretch and Jokes/Readings. No times were scheduled for these activities.</p> <p>An interview was conducted on 2/28/14 at 3:07 p.m. with the nurse on duty, LPN #10, regarding scheduled activities for the day. She indicated the CNA's were responsible for activities, and it had been that way since last year. She stated, "We need both CNAs to do the ADLs (activities of daily living) and stuff, so there's not necessarily enough staff. It's not realistic for 1 CNA to be doing activities. We need 3 CNAs, not 2. We have 26 residents." She indicated she did not see Spiritual Reflections or Jokes/Reading done that day. She indicated she saw Mind Stretch which was "questions about their past more or less" with 6 or 7 residents with CNA (Certified Nursing Assistant) #16 after lunch.</p> <p>A second observation was made on 3/4/14 at 1:41 p.m. of Resident #27 sitting, with her eyes closed, dozing in the sitting room of the Alzheimer's Care Unit (ACU). Seven other residents were present, but no staff member was present. Resident #27 was not watching</p>			

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	<p>television, listening to music, having a conversation or engaging in any sort of activity.</p> <p>On 3/4/14 at 2:17 p.m. and 2:48 p.m., Resident #27 was observed sitting in the same spot with her eyes closed.</p> <p>An interview was conducted with CNA #12 on 3/4/14 at 1:49 p.m. regarding the activity program on the ACU. She indicated only 2 CNA's were scheduled per shift. She stated she and CNA #13 were the 2 CNAs currently on duty. She stated, "It's normally just 2 of us, a nurse and the Unit Coordinator. Today I did an activity of manicures about 10:30 (a.m.). I painted 6 residents' nails. (Name of Resident #27) was sleeping at the time...I worked from 6-2 (p.m.) today. I work down here maybe once a week, day shift. I have never been assigned to just do activities consistently. I have never seen a consistent activity program down here. There's plenty of down time here...When I'm here, I'll do an activity once between 9:30 and 10:30 (a.m.). This unit is consistent (sic) taking residents to the restroom, so it would not be reasonable for me to conduct a consistent activity program." She indicated no one had ever discussed what activities were appropriate for residents with Alzheimer's dementia. "Some residents were not interested in the manicure at all. I've seen in other facilities where an Alzheimer's unit has it's own activity program, and that works better. I wouldn't really know how to do certain activities with them. It would be a good idea to have someone down here who's trained to do activities with people who have Alzheimer's. "</p> <p>An interview was conducted with CNA #13 on 3/4/14 at 2:14 p.m. regarding the activity</p>			

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	<p>program. She stated, "I have not done an activity with them today, but (name of CNA #12) did nails. I haven't had time to do an activity, because I've been providing care. I could probably do 15 minutes per shift of activity time, and the other aide could do 15 minutes for a total of 30 minutes from about 6:00 (a.m.) to 2:00 (p.m.). We did activities on a regular basis when we had 3 CNA's back here. We stopped having the 3rd CNA maybe 6 months ago. Since then, the 2 CNA's who are back here only have time to do ADL stuff. I get here at 6 (a.m.), start showers, strip the beds, go around and do ADL's on non showers, get residents to the dining room for breakfast by 8:00 (a.m.), then assist with dining at breakfast, then clean up. By now, it's 9:30 or 10:00 (a.m.) and we pass snacks in the sitting/TV room. That's when, maybe, we can do an activity. About 10:30 (a.m.), I take a break until 11:00 (a.m.). I set up for lunch, do care tracker (CNA database), then bring residents to the dining room about 11:45, lunch at 12:00 (p.m.), then assist with dining until 1:30 (p.m.), then we're doing care tracker stuff like bowel and bladder, consumption. Oh and we take out trash. Then I'm off at 2:00 (p.m.). When we had 3 CNA's down here, it was a lot easier with the extra help. One could do activities; one could do care tracker; one could do ADLs and we could rotate. There was always something going on with activities. The care (level of care) has also increased so we do the care, but basically, what had to be eliminated was spending time with the residents. We don't do that as much." She also indicated, "No one has ever given me training on specific activities for residents with Alzheimer's dementia."</p> <p>An interview was conducted with the</p>			

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	<p>Alzheimer's Care Unit Coordinator on 3/4/14 at 2:48 p.m. regarding the activity program. She indicated, "I am in charge of planning activities. CNAs are responsible for implementing it. We have things set up, but not as blocked time, because things change back here. It is our goal to do the activities on the schedule, but they vary...We don't have scheduled activities. There is not a scheduled activity right now." Regarding whether the CNA's on the unit had any type of training for activities, she indicated, "The CNAs have annual dementia training, but nothing specific to recreational activities for Alzheimer's residents. I'm not sure if anyone has thought about that. I haven't. I don't have a recreational therapy background. We have not supplied recreational activity training back here. There's no way for us to have a nonstop activity program back here. We'd need another staff member. The CNA's can't do ADLs and activities at the same time."</p> <p>A final observation was made on 3/6/14 at 10:34 a.m. of Resident #27 sitting in the sitting room in a chair with her eyes closed, not watching TV or doing anything.</p> <p>An interview was conducted with the Recreational Therapist on 3/5/14 at 2:19 p.m. He stated, "I am not Activity Director over Memory Care (ACU). They are under the social model, so CNA's do a lot...I have never worked on an Alzheimer's unit." Regarding the types of activities most beneficial for residents with Alzheimer's dementia, he indicated, "Alzheimer's residents definitely benefit from music therapy, trying to revert back to their past, doing reminiscent things, like the good old days. There's a game it's called memory something. It takes cue cards with common phrases like "You never know</p>			

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	<p>the worth of water until the well runs...and then the resident says "dry" or it's better to be late than, and they'd say "never". I have taken some of those residents from that unit on a drive. The last time was probably fall, when the seasons changed."</p> <p>3. A review of Resident #25's clinical record was performed on 3/3/14 at 10:08 a.m. The Resident's diagnoses included, but were not limited to, unspecified infantile cerebral palsy, unspecified cerebral degeneration, moderate intellectual disabilities.</p> <p>A Significant Change MDS Minimum Data Set) Assessment, dated 11/1/13, for Resident #25 indicated the following preferences for Resident #25, music, pet visits, "doing things with groups of people", spending time outdoors.</p> <p>On 3/3/14 at 2:50 p.m., during an observation, Resident #25 was observed in bed watching TV 3/3/14 2:50 pm.</p> <p>On 3/4/14 at 10:03 am, Resident #25 was observed lying in his bed in his room with his eyes closed and was wearing a hospital gown. No one else was observed in the room.</p> <p>On 3/4/14 at 10:29 a.m., the Social Services Director indicated no resident should have only 2 hrs of scheduled activities a month, especially a resident who was confined to bed for the majority of the day by physician orders. She indicated Resident #25's activities and social interaction should be more than was currently provided by the facility.</p>						

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	<p>On 3/4/14 at 11:18 a.m., during an interview, the Activities Director indicated Resident #25 does not come frequently to group activities due to impaired skin issues and guidance from nursing that Resident #25 needed frequent time in bed. He indicated Resident #25 enjoys group social activities and would benefit from interaction with other residents in group activities. He indicated a resident who was confined to bed by a physician's order should have "extra activities" planned to keep them from declining psychosocially.</p> <p>On 3/4/14 at 11:20 a.m., Resident #25 was observed lying in his bed in his room wearing a hospital gown. No one else was present in the room. Resident #25 was not observed to be engaged in any activity.</p> <p>On 3/4/14 at 11:27 a.m., CNA/Activities Assistant #6 indicated Resident #25 does not come to group activities much due to skin wound problems. She indicated nursing staff has advised activities staff to do independent activities with the resident in his room.</p> <p>On 3/4/14 at 1:46 p.m., the Assistant Director of Nursing(ADON)/Wound Nurse indicated Resident #25's left ischial wound was "healed over" as of 12/2013 and the order in place to have resident #25 remain in bed should have been discontinued in December of 2013.</p> <p>On 3/4/14 at 2:19 pm, CNA #7 indicated Resident #25 had eaten in his bedroom "ever since I've been here." She indicated she has been employed at the facility since "the middle of January" 2014.</p> <p>On 3/4/14 at 2:48 p.m., CNA #7 provided a copy of a facility "CNA Assignment Sheet" which indicated the following regarding</p>			

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	<p>Resident #25's care: "...resident is to be up mon, wed, fri from 12 pm -2 pm only no extra time..." .</p> <p>On 3/4/14 at 3:27 p.m., Resident #25 indicated he enjoys social group activities and generally enjoys being in the company of other residents.</p> <p>On 3/4/14 at 4:58 p.m., Resident #25's family member indicated Resident #D very much enjoyed social interaction and group activities. The family member indicated the facility was made aware of Resident #25's social preferences upon admission to the facility.</p> <p>A physician's order, dated 11/27/13, indicated the following: "...Resident (#25) is to remain in bed until wound is healed except for schedule(sic) weights and showers..."</p> <p>On 3/5/14 at 9:42 a.m., Resident #25 was lying in bed on his back. His roommate was in another room bed and there was a curtain divider between the two beds. No communication was taking place between the residents at the time and no other people were present in the room.</p> <p>A facility document, referred to as an "activity log" by the Activities Director, was reviewed. It indicated Resident #25 participated in programmed activities on 11/2/13 for 25 minutes, 11/6/13 for 20 minutes, 11/7/13 for 20 minutes, 11/11/13 for 20 minutes, 12/2/13 for 20 minutes, 12/11/13 for 30 minutes, 12/9/13 for 20 minutes, 12/18/13 for 25 minutes, 1/7/14 for 15 minutes, 1/13/14 for 20 minutes, 1/21/14 for 20 minutes, 2/10/14 for 25 minutes, 2/15/14 for 30 minutes, 2/17/14 for 25 minutes, and 2/19/14 for 25</p>			

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F000250 SS=D	<p>minutes. This record indicated pet visits were performed with Resident #D on 11/9/13, 11/16/13, 11/23/13, 12/7/13, 12/14/13, 12/21/13, 1/4/14, and 1/18/14. The Activities Director indicated the facility could provide no other documentation regarding programmed activities for Resident #25 between November, 2013 and March 4th, 2014.</p> <p>A care plan for Resident #25 indicated the following: "...I have a dx(diagnosis of) moderate intellectual disabilities. I would enjoy being out of bed daily as I desire and as tolerated..." and "...I would enjoy being engaged in social visits in my room..."</p> <p>A PASRR(Preadmission Screening and Resident Review), dated 8/29/13, was reviewed. It indicated "...Resident #25) benefits from encouragement to routinely participate in a variety of activities that promote cognitive, social, and sensory stimulation. He benefits from assistance to be up in his gerichair and to attend preferred activities as tolerated..."</p> <p>An activities care plan for Resident #25 indicated the following: "...Assist me to and from activities as needed..." and "...If I become less involved in group activities, please offer me independent or 1:1 activities that I enjoy..." and "...Invite me to "sit in" during activity programs if I'd rather watch than actively participate..."</p> <p>3.1-33(a) 3.1-33(e)(1) 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the</p>						

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	<p>highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident had clothing to wear. This affected 1 of 4 residents reviewed for dignity. (Resident #176). The facility also failed to ensure a PASAR (Preadmission Screening and Resident Review) recommendation was followed for 1 of 1 residents reviewed of 3 who met the criteria for PASAR. (Resident #25)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #176 was reviewed 2/28/14 at 11:00 a.m. The diagnoses for Resident #176 included, but were not limited to, dysphagia, blindness, and psychosis. Resident #176's admission date was 2/13/14.</p> <p>During an interview with Resident #176, on 2/2/8/14 at 11:22 a.m., the Resident indicated they did not want to wear what they had on and it was the only clothing available to them. Resident was observed to be in a hospital gown. Resident #176 also indicated no one had asked what they would like to wear or if they had any clothes to wear.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 2/20/14, indicated Resident #176 had a BIMS (Brief Interview of Mental Status) of 13, which is indicative of cognitively intact.</p> <p>During the following observations, Resident #176 was wearing a hospital gown: 2/28/14 at 1:55 p.m.</p>	F000250	<p>F250</p> <p>It is the practice of this facility to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #176 was given clothing. Resident #25 was assisted to geri-chair and taken to activities.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents audited to ensure clothing in place. All Level 2 residents reviewed to ensure PASRR recommendations are followed and in plan of care. No adverse outcomes related to the deficient practice.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient</p>	04/05/2014

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	<p>3/3/14 at 2:00 p.m. 3/3/14 at 2:30 p.m.</p> <p>On 3/3/14 at 2:30 p.m., Resident #176 indicated they still don't have any other clothing and no one had asked if they would like to wear everyday clothes instead of a hospital gown. Resident #176 then indicated to look in their closet and drawer. No clothing was observed in the Resident's room.</p> <p>At 2:35 p.m., on 3/3/14, the Administrator indicated if staff determined a Resident does not have any clothing, then the facility has clothing the Resident can use or the facility will go out and buy clothing. He indicated Social Services was in charge of completing this task.</p> <p>During an interview with the Social Services Director, on 3/3/14 at 2:38 p.m., she indicated she was unaware that Resident #176 had no clothing at the facility. She also indicated Nursing staff was supposed to notify her and no one did.</p> <p>A policy titled, Resident Rights, dated 10/09, was received from the Director of Nursing on 3/3/14 at 10:28 a.m. It indicated, "...the social services staff will promote the following types of staff interactions with residents, which maintain their dignity...assisting with the purchase of personal clothing that is clean, in good repair,...and appropriate to time of day and individual preferences...."</p> <p>2. A review of Resident #25's clinical record was performed on 3/3/14 at 10:08 a.m. The resident's diagnoses included, but were not limited to, unspecified infantile cerebral palsy,</p>		<p>practice does not recur are as follows:</p> <p>Resident guardian angels will assess the need for clothing for their residents and discuss any residents that do not have appropriate clothing in the daily morning meeting with the leadership team. Social Services to ensure that residents have clothing of preference for dress. All Level 2 residents will be reviewed upon admission by Social Services and care plans implemented to reflect PASRR recommendations.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Director of Nursing Services, Assistant Director of Nursing Services, and Social Services staff will review resident guardian angel room round sheets weekly x 8 weeks, then monthly to ensure proper clothing. Social Services to audit Level 2 residents and ensure residents' PASRR recommendations are being followed weekly x 8 weeks, then monthly. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p>	

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	<p>unspecified cerebral degeneration, moderate intellectual disabilities.</p> <p>A PASRR(Preadmission Screening and Resident Review), dated 8/29/13, was reviewed. It indicated "...(Resident #25) benefits from encouragement to routinely participate in a variety of activities that promote cognitive, social, and sensory stimulation. He benefits from assistance to be up in his gerichair and to attend preferred activities as tolerated..."</p> <p>Resident #D was observed in bed watching TV, on 3/3/14 at 2:50 pm. No one else was present in the room.</p> <p>On 3/4/14 at 10:03 a.m., Resident #25 was observed lying in bed in his room, with his eyes closed. No one else was observed in the room.</p> <p>On 3/4/14 at 11:20 a.m., Resident #25 was observed lying in bed in his room. Another resident was in the other bed with a curtain divider between the residents. No communication was taking place between the residents at the time.</p> <p>On 3/5/14 at 9:42 a.m., Resident #25 was lying in bed, in his room. His eyes were open and he did not appear to be engaged in any activities. His roommate was in another bed and there was a curtain divider between the two beds. No communication was taking place between the residents at the time and no other persons were present in the room.</p> <p>A facility document, referred to as an "activity log" by the Activities Director, was reviewed. It indicated Resident #25 participated in programmed activities on 11/2/13 for 25</p>		<p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>	
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	<p>minutes, 11/6/13 for 20 minutes, 11/7/13 for 20 minutes, 11/11/13 for 20 minutes, 12/2/13 for 20 minutes, 12/11/13 for 30 minutes, 12/9/13 for 20 minutes, 12/18/13 for 25 minutes, 1/7/14 for 15 minutes, 1/13/14 for 20 minutes, 1/21/14 for 20 minutes, 2/10/14 for 25 minutes, 2/15/14 for 30 minutes, 2/17/14 for 25 minutes, and 2/19/14 for 25 minutes. This record indicated pet visits were performed with Resident #D on 11/9/13, 11/16/13, 11/23/13, 12/7/13, 12/14/13, 12/21/13, 1/4/14, and 1/18/14.</p> <p>On 3/4/14 at 10:29 a.m., during an interview, the Social Services Director indicated no resident should have only 2 hrs of scheduled activities a month, especially a resident who was confined to bed for the majority of the day by physician orders. She indicated Resident #25's activities and social interaction should be more than are currently provided by the facility.</p> <p>On 3/4/14 at 11:18 a.m., during an interview, the Activities Director indicated Resident #25 does not come frequently to group activities due to impaired skin issues and guidance from nursing that Resident #25 needs requires frequent time in bed. He indicated Resident #25 enjoys group social activities and would benefit from interaction with other residents in group activities. He indicated a resident who was confined to bed by a physician's order should have "extra activities" planned to keep them from declining psychosocially. The Activities Director indicated the facility could provide no documentation regarding which programmed activities for Resident #25, other than monthly activity logs, between November, 2013 and March 4th, 2014.</p>			

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	<p>On 3/4/14 at 11:27 a.m., during an interview, CNA/Activities assistant #6 indicated Res #25 does not come to group activities much due to skin wound problems. She indicated nursing staff has advised activities staff to do independent activities with the resident in his room. She indicated she performed various activities with Resident #25 "in his room" between 11/1/13 and 3/1/14.</p> <p>On 3/4/14 at 1:46 p.m., during an interview, the Assistant Director of Nursing/Wound Nurse indicated Resident #25's left ischial wound was "healed over" as of 12/2013 and the order in place to have Resident #25 remain in bed should have been discontinued in December of 2013.</p> <p>On 3/4/14 at 2:19 pm, CNA #7 indicated Resident #25 has eaten in his bedroom "ever since I've been here." She indicated she has been employed at the facility since "the middle of January" 2014.</p> <p>On 3/4/14 at 3:27 p.m., Resident #25 indicated he enjoys social group activities and generally enjoys being in the company of other residents.</p> <p>On 3/4/14 at 4:58 p.m., Resident #25's family member indicated Resident #25 very much enjoyed social interaction and group activities. The family member indicated the facility was made aware of Resident #25's social preferences upon admission to the facility.</p> <p>On 3/6/14, at 12:40 p.m., during an interview, the Social Services Director indicated the current PASRR recommendation #7, which stated the following: "...(Resident #25) benefits from</p>			

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F000279 SS=D	<p>encouragement to routinely participate in a variety of activities that promote cognitive, social, and sensory stimulation. He benefits from assistance to be up in his gerichair and to attend preferred activities as tolerated..." was care planned for Resident #25. She indicated the Social Services department was in charge of overseeing whether PASRR recommendations were being properly implemented. She again indicated Resident #25 was not receiving adequate social interactions provided by the facility as directed by the PASRR recommendations and the care plans.</p> <p>3.1-34(a) 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to 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>	F000279	F279				

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	<p>Based on observation, interview, and record review, the facility failed to develop a care plan for a resident's preference for dressing for 2 of 4 residents reviewed for dignity. (Resident #3 and #175) The facility also failed to develop a care plan for contractures for 1 of 1 residents reviewed of 7 who met the criteria for range of motion (Resident #25).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #3 was reviewed 3/3/14 at 11:30 a.m. The diagnoses for Resident #3 included, but were not limited to, malaise, depression, and congestive heart failure.</p> <p>During an interview with Resident #3, on 2/27/14 at 3:24 p.m., she indicated she prefers to wear a hospital gown.</p> <p>A review of Resident #3's 30 day MDS (Minimum Data Set) Assessment indicated Resident #3 had a BIMS (Brief Interview of Mental Status) of 14, which was indicative of being cognitively intact.</p> <p>During the following observations, Resident #3 was wearing a hospital gown: 2/28/14 at 9:50 a.m., 2/28/14 at 11:20 a.m., 2/28/14 at 1:55 p.m.</p> <p>On 3/5/14, at 10:45 a.m., the Social Services Director indicated Resident #3 prefers to wear a hospital gown.</p> <p>During an interview with Director of Nursing (DoN), on 3/5/14 at 1:15 p.m., she indicated expected dress for Residents in the facility was "everyday" clothes. The DoN further</p>		<p>It is the practice of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #3 and resident #175 have had a care plan developed for preference of dress. Resident #25 has had a care plan developed for contractures and passive range of motion.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>An audit of all residents' dressing preference by interview and observation conducted, and care plans implemented to match preference. An audit of all residents with contractures conducted, and care plans implemented accordingly for contractures and passive range of motion.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient</p>	

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	<p>indicated, if a Resident prefers a hospital gown, that would be a unique situation and a care plan should be developed for this preference. The DoN indicated at this time, she was unable to locate a care plan for Resident #3's preference for dressing in a hospital gown.</p> <p>2. The clinical record for Resident #175 was reviewed 3/3/14 at 1:45 p.m. The diagnoses for Resident #175 included, but were not limited to, metabolic encephalopathy, depression, psychosis, and chronic systolic heart failure.</p> <p>During the following random observations, Resident #175 was observed to be in a hospital gown: 2/28/14 at 2:15 p.m., 3/3/14 at 2:30 pm., and 3/6/14 at 11:15 a.m.</p> <p>During an interview with Family Member #16, on 3/6/14 at 11:15 a.m., she indicated Resident #175 preferred to be dressed in a hospital gown.</p> <p>On 3/6/14 at 2:03 p.m. the DoN indicated she was unable to locate a hospital gown dressing preference care plan for Resident #175.</p> <p>3. A review of Resident #25's clinical record was performed on 3/3/14 at 10:08 a.m. The resident's diagnoses included, but were not limited to, unspecified infantile cerebral palsy, unspecified cerebral degeneration, moderate intellectual disabilities.</p> <p>A physical therapy screening form, dated 3/22/12 indicated the following: "...pt(Resident #25) has BLE(bilateral lower</p>		<p>practice does not recur are as follows:</p> <p>All nursing staff in-serviced on resident rights for preference of dress and care plans. All nursing staff in-serviced on passive range of motion, contractures, and care plans. Preferences of dress added to resident guardian angel room rounds to ensure all residents are observed daily and careplanned accordingly. All residents will be assessed by the Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers upon admission and quarterly for contractures or development of contractures.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Director of Nursing Services and Assistant Director of Nursing Services will audit passive range of motion being performed and corresponding care plan of affected residents with contractures 3 times per week x 4 weeks, then monthly for compliance of residents with contractures receiving passive range of motion with corresponding care plan. The Director of Nursing Services, Assistant Director of Nursing</p>	

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	<p>extremity) contracture..."</p> <p>On 3/3/14 at 10:57 a.m., during an observation, Resident #25 was lying in his bed in his room. His lower extremities were contracted upwards diagonally across his body towards his left hip area.</p> <p>On 3/4/14 at 10:03 am, during an observation, Resident #25 was observed lying in bed. His lower extremities appeared contracted up toward his left hip area.</p> <p>On 3/5/14 at 9:45 a.m., during an interview, the ADON/Wound nurse indicated Resident #25 should have had some sort of passive range of motion therapy, implemented by nursing, for his lower extremity contractures. She indicated she did not see a care plan in place for lower extremity contractures, but she indicated there should be one. She indicated nursing should have care planned passive range of motion for Resident #25 and nursing should have been performing passive range of motion services for Resident #25.</p> <p>On 3/5/14 at 9:57 a.m., during an interview, the MDS Director identified herself as the coordinator for the "restorative" program for the facility. She indicated this was the program that coordinates passive range of motion services along with nursing. She indicated no passive range of motion services were in place for Resident #25's lower extremity contractures.</p> <p>On 3/5/14 at 10:11 a.m., the Director of Therapy Services indicated Resident #25 would benefit from passive range of motion services. She also indicated, "it can help prevent further decline." She indicated the therapy department had not provided any</p>		<p>Services, and Social Services staff will observe resident in non-traditional dress to current care plan to confirm accuracy 3 times per week x 4 weeks, 2 times per week x 4 weeks, then monthly for compliance. Findings of the audits and observations will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>	

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F000280 SS=D	<p>lower extremity contracture range of motion services between March 1st, 2013 and March 1st, 2014 for Resident #25.</p> <p>3.1-35(a) 3.1-35(b)(1) 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to update a nutrition care plan for 1 of 3 residents reviewed for nutrition. (Resident #88)</p> <p>Findings include:</p> <p>Resident #88's clinical record was reviewed on 3/4/2014 at 1 pm. The Resident's diagnoses included but were not limited to, stroke, depressive disorder, pain, glaucoma, anxiety, gastroesophageal reflux disease.</p>	F000280	<p>F280</p> <p>It is the practice of this facility that the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and the treatment or changes in care and treatment.</p> <p>What corrective actions will be accomplished for those residents found to have been</p>	

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	<p>A nutrition care plan, dated revised on 9/18/2012, indicated, "Interventions: Diet as ordered: mec (mechanical) soft, NSP (no salt packet) with pureed vegetables...."</p> <p>An MD order, dated 12/21/2013, indicated, "diet: NSP, puree texture, add whole milk with all meals. House supplement shake at bedtime. Chocolate milk at all meals."</p> <p>A nutrition assessment summary indicated, "2/5/2014: Diet NSP puree, whole milk all meals. Res also gets fortified pudding w/ (with) lunch and dinner, also gets a house shake at bedtime for nutritional support."</p> <p>An interview with the Registered Dietician (RD), on 3/5/2014 at 10:46 am indicated Resident #88's nutrition care plan was not updated because, "it just got missed somehow. Usually I update the care plan right after I review him, but sometimes I wait for the MD to actually write the new order, so that the care plan is correct, before I update it."</p> <p>3.1-35(b)(2)</p>		<p>affected by the deficient practice are as follows:</p> <p>Resident #88 nutritional care plan updated.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents' nutritional care plans audited and updated as needed to reflect current plan of care.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>All nursing staff in-serviced on nutritional care plans and updated care plans as changes occur. Nutritional care plans will be reviewed in weekly weight management meeting with IDT in attendance. All changes to nutrition made in weekly weight management meeting will be updated in meeting at time of occurrence. New diet orders that are changed by physician and not related to weight management committee will be reviewed in daily morning meeting by IDT, and changes in nutritional status</p>	

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F000282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure	F000282	to be implemented on care plan in daily morning meeting. How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: The Director of Nursing Services, Assistant Director of Nursing Services, and Registered Dietitian will audit nutritional care plans 3 times per week x 4 weeks, 2 times per week x 4 weeks, weekly x 4 weeks, then monthly thereafter to ensure nutritional intake matches current nutritional care plan. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations. By what date the systemic changes will be completed is as follows: 4/5/14. F282 It is the practice of this facility that	

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	<p>resident's plans of care were followed for 3 of 31 of residents reviewed for care plans. (Resident #'s 115, 21, & 25). The facility also failed to ensure physician's orders were followed for 2 of 5 residents reviewed for unnecessary medications and failed to develop an immediate plan of care for a resident identified as at risk for developing pressure ulcers per facility policy for 1 of 3 residents reviewed for pressure ulcers of the 3 who met the criteria. (Resident #178 & Resident #160)</p> <p>Findings include:</p> <p>1. Resident #115's clinical record was reviewed on 3/4/2014 at 12:20 pm. The Resident's diagnoses included but were not limited to, dementia, anemia, glaucoma, muscle weakness, and glaucoma.</p> <p>Observations of Resident #115 indicated she was sitting in a wheelchair with her feet resting on foot pedals and she had on regular socks with no shoes, on the following times; 2/28/2014 at 2:11 am, on 3/4/2014 at 12:26 pm, and at 2:30 pm.</p> <p>A care plan, dated 6/17/2013, indicated, "Focus: I have a physical functioning deficit r/t (related to) self care impairment, mobility impairment. Interventions: Dressing assistance as needed."</p> <p>An interview with CNA #3, on 3/5/2014 at 10:35 am, indicated Resident #115 doesn't wear shoes because one of her feet is "curled" and shoes don't fit right on her, it would probably hurt her to wear shoes.</p> <p>An interview with Unit Manager #1, on 3/5/2014 at 2:33 pm, indicated she checked</p>		<p>the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #160 no longer in facility. Resident #115 with care plan for wearing sock, no shoes. Resident #21 with care plan for not wearing shoes, and socks with name created by label maker given to resident. Resident #25 care plan updated to reflect PASRR recommendations. Resident #178 was weighed. Resident #178 had PT/INR drawn. Resident #25 order clarified, bed rest lifted.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>Audit completed of all new admissions in month of March with antibiotics. Findings reported to MD. Audit completed of all residents that prefer not to wear shoes have care plan. Audit completed of March current weekly weights. Physician</p>	

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	<p>the resident's foot, she doesn't have a contracture. She has a hammertoe. She asked the resident if its ok with her if she just wears socks, or just slippers and resident responded this was ok.</p> <p>2. Resident #21's clinical record was reviewed on 3/4/2014 at 9:30 am. The Resident's diagnoses included but were not limited to, dementia, depression, severe malnutrition, anemia, diabetes, anxiety.</p> <p>An observation of Resident #21, on 2/28/2014 at 2:07 pm, indicated he was sitting in his wheelchair with no foot pedals attached, with his feet on ground, and he had on regular socks with no shoes.</p> <p>An observation of Resident #21, on 3/4/2014 at 9:48 am, indicated he was participating in a ball toss activity in the activity room. He was seated in his w/c, had on socks and his feet were resting on the floor. He had no shoes on. His socks were labeled with his last name in large letters, written in black marker.</p> <p>An observation of Resident #21, on 3/4/2014 at 12:23 pm, indicated he was seated in his wheelchair in the dining room eating lunch. He had on socks and his feet were resting on the floor. He had no shoes on. His socks were labeled with his last name in large letters, written in black marker. At 2:30 pm, he was sitting in his wheelchair across from nursing station and he was wearing socks labeled with his last name and no shoes.</p> <p>A care plan, dated 9/23/2011, indicated, "Focus: I have a physical functioning deficit r/t self care impairment, mobility impairment. Interventions: Dressing assistance."</p>		<p>notified of missing weights. Audit completed of all resident's receiving PT/INRs in March. Physician notified of any missing PT/INRs. Audit completed of all residents with plan of care for pressure ulcers. Audit completed of all residents on bed rest.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>All licensed nursing staff will be in-serviced on medication reconciliation policy and medication review of admission/re-admission guidelines. Upon new admission/re-admission, license nurse will input all medications as ordered. A second nurse will review all medications in PCC (nursing documentation system) against MAR/TAR, discharge summary, and transfer forms. The nurse completing the second reconciliation will note his/her name and date on the bottom of the physicians order summary per policy. Resident guardian angel room rounds will be conducted 5x a week and residents will be observed for preference of not wanting to wear shoes. Label maker purchased and all sock and clothing will be inconspicuously labeled to protect confidentiality. All weekly weights</p>	

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	<p>An interview with CNA #2, on 3/5/2014 at 10:34 am, indicated he doesn't wear shoes because he has a bunion on one of his feet, so it would hurt his foot if he wore shoes. CNA #2 indicated, "(The resident's) wife told me not to put shoes on him because of the bunion."</p> <p>3. A review of Resident #25's clinical record was performed on 3/3/14 at 10:08 a.m. The resident's diagnoses included, but are not limited to, unspecified infantile cerebral palsy, unspecified cerebral degeneration, moderate intellectual disabilities.</p> <p>An activities care plan for Resident #25 indicated the following: "...I will continue to participate in the activities of my choice...". Some of the interventions associated with this care goal were listed as: "...Invite me to "sit in" during activity programs..." and "...Assist me to and from activities as needed..." This care plan also listed some of Resident #25's favorite activities as: "...outdoor activity...enjoys going places...enjoys being around others; visiting with others..."</p> <p>A PASRR(Preadmission Screening and Resident Review), dated 8/29/13, was reviewed. It indicated "....(Resident #25) benefits from encouragement to routinely participate in a variety of activities that promote cognitive, social, and sensory stimulation. He benefits from assistance to be up in his gerichair and to attend preferred activities as tolerated..."</p> <p>On 3/3/14 at 2:50 p.m., during an observation, Resident #25 was observed</p>		<p>collected and entered into PCC by Director of Nursing Services. Director of Nursing Services will implement and oversee weight monitoring program per facility policy. PT/INRs will be monitored per facility policy with PT/INR flow sheets. Orders will be reviewed in daily morning meeting to ensure that if resident is placed on bed rest or isolation, the entire IDT is aware and activities can be scheduled accordingly. Immediate plan of care for pressure ulcers will be implemented within 7 days of new admission.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>The Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will audit all new admissions/re-admissions within 24 hours to insure two nurses have verified and entered all orders correctly in PCC (nursing documentation system). This will be completed on every new admission/re-admission indefinitely per Golden Living Center Policy. Director of Nursing Services and Assistant Director of Nursing Services will observe population and audit care plans related to resident's</p>		

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	<p>lying in bed and no one else was present in the room. No music was heard playing in the room at the time.</p> <p>On 3/4/14 at 10:03 am, Resident #25 was observed lying in bed, in his room, with his eyes closed. No one else was observed in the room. No music was heard playing at the time.</p> <p>On 3/4/14 at 11:20 a.m., Resident #25 was observed lying in bed in his room, another resident was in the other bed with a curtain divider between the residents. No communication was taking place between the residents at the time. No music was heard playing in the room at the time.</p> <p>On 3/5/14 at 9:42 a.m., Resident #25 was lying in bed, in his room, on his back. His eyes were open and he did not appear to be engaged in any activities. His roommate was in another room bed and there was a curtain divider between the two beds. No communication was taking place between the residents at the time and no other persons were present in the room.</p> <p>On 3/4/14 at 10:29 a.m., during an interview, the Social Services Director indicated no resident should have only 2 hrs of scheduled activities a month, especially a resident who was confined to bed for the majority of the day by physician orders. She indicated Resident #25's activities and social interaction should be more than are currently provided by the facility.</p> <p>On 3/4/14 at 11:18 a.m., the Activities Director indicated Resident #25 does not come frequently to group activities due to impaired skin issues and guidance from</p>		<p>preference to not wear shoes and corresponding care plan 3 times per week x 4 weeks, 2 times per week x 4 weeks, weekly x 4 weeks, then monthly. Director of Nursing Services and Assistant of Nursing Services to audit PT/INR tracking logs 3 times per week x 4 weeks, 2 times per week x 4 weeks, weekly x 4 weeks, then weekly. Director of Nursing Services will ensure all weekly weights are obtained and entered into PCC correctly every week indefinitely. Director of Nursing Services and Assistant of Nursing Services will review orders daily to ensure no new resident's on bed rest/isolation indefinitely. Social Services will audit Level 2 residents and insure resident's PASRR recommendations are being followed weekly x 8 weeks, then monthly. Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will audit all new admissions to insure immediate plan of care for pressure ulcers is implemented within 7 days. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>		

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	<p>nursing that Resident #25 needs requires frequent time in bed. He indicated Resident #25 enjoys group social activities and would benefit from interaction with other residents in group activities. He indicated a resident who was confined to bed by a physician's order should have "extra activities" planned to keep them from declining psychosocially. The Activities Director indicated the facility could provide no documentation regarding which programmed activities for Resident #25, other than monthly activity logs, between November, 2013 and March 4th, 2014.</p> <p>A facility document, referred to as an "activity log" by the Activities Director, was reviewed. It indicated Resident #25 participated in programmed activities on 11/2/13 for 25 minutes, 11/6/13 for 20 minutes, 11/7/13 for 20 minutes, 11/11/13 for 20 minutes, 12/2/13 for 20 minutes, 12/11/13 for 30 minutes, 12/9/13 for 20 minutes, 12/18/13 for 25 minutes, 1/7/14 for 15 minutes, 1/13/14 for 20 minutes, 1/21/14 for 20 minutes, 2/10/14 for 25 minutes, 2/15/14 for 30 minutes, 2/17/14 for 25 minutes, and 2/19/14 for 25 minutes. This record indicated pet visits were performed with Resident #D on 11/9/13, 11/16/13, 11/23/13, 12/7/13, 12/14/13, 12/21/13, 1/4/14, and 1/18/14.</p> <p>On 3/4/14 at 11:27 a.m., CNA/Activities assistant #6 indicated Res #25 does not come to group activities much due to skin wound problems.</p> <p>On 3/4/14 at 1:46 p.m., the Assistant Director of Nursing/Wound Nurse indicated Resident #25's left ischial wound was "healed over" as of 12/2013 and the order in place to have resident #25 remain in bed should have been discontinued in December of 2013.</p>			

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	<p>On 3/4/14 at 2:19 PM, during an interview, CNA #7 indicated Resident #25 has eaten in his bedroom "ever since I've been here." She indicated she has been employed at the facility since "the middle of January" 2014.</p> <p>On 3/4/14 at 3:27 p.m., Resident #25 indicated he enjoys social group activities and generally enjoys being in the company of other residents.</p> <p>On 3/4/14 at 4:58 p.m., Resident #25's family member indicated Resident #25 very much enjoyed social interaction and group activities. The family member indicated the facility was made aware of Resident #25's social preferences upon admission to the facility.</p> <p>A physician's order, dated 11/27/13, indicated the following: "...Resident (#25) is to remain in bed until wound is healed except for schedule(sic) weights and showers..."</p> <p>On 3/6/14, at 12:40 p.m., during an interview, the Social Services Director indicated the current PASRR recommendation #7, which stated the following: "... (Resident #25) benefits from encouragement to routinely participate in a variety of activities that promote cognitive, social, and sensory stimulation. He benefits from assistance to be up in his gerichair and to attend preferred activities as tolerated..." was care planned for Resident #25. She indicated the Social Services department is in charge of overseeing whether PASRR recommendations are being properly implemented. She again indicated Resident #25 was not receiving adequate social interactions provided by the facility as</p>			

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	<p>directed by the PASRR recommendations and the care plans.</p> <p>4. The clinical record for Resident #178 was reviewed 3/4/14 at 11:30 a.m. The diagnoses for Resident #178 included, but were not limited to, debility, chronic thrombosis of deep veins of upper extremity, dysphasia, and renal failure.</p> <p>A review of the February Physician's Orders indicated an order for weekly weights starting on 2/11/14 for 4 weeks. The Physician's Orders also indicated an order for PT/INR (blood clotting test) on Mondays and Thursdays weekly starting on 2/13/14.</p> <p>A review of the weights for Resident #178 indicated the following dates/weights: 2/7/14-168.2, 2/8/14-168.1, 2/9/14-162.1, 2/11/14-165.6, & 3/2/14-166.</p> <p>A review of the PT/INRs for Resident #178 indicated the following dates/values: 2/13/14=PT-17.2, INR-1.6, 2/17/14=PT-19.3, INR-1.8, 2/20/14=PT-24.3, INR-2.2, & 2/27/14=PT-17.4, INR-1.6. The (name of lab company) lab sheets indicated standard anticoagulant values for INR was 2.0-3.0.</p> <p>During an interview with Registered Dietician, on 3/5/14 at 10:20 a.m., she indicated weights for Resident #178 were missing for</p>			

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	<p>two weeks-2/18/14 and 2/25/14. She further indicated she will try and locate the missing weekly weights.</p> <p>On 3/5/14, at 11:00 a.m., the Director of Nursing (DoN) indicated the missing PT/INR lab on 2/25/14 was not done, as ordered. She also indicated weights were not being done appropriately in the facility, but she had initiated a new program, since her arrival last week. The DoN indicated she will further look into if the weekly weights were done, as ordered.</p> <p>At 10:50 a.m., on 3/6/14, the DoN indicated the weekly weights for Resident #178 were not done as ordered and she was not sure why.</p> <p>5. The clinical record for Resident #160 was reviewed on 3/3/14 at 11:32 a.m. The diagnoses for Resident #160 included, but were not limited to, dehydration and urinary tract infection.</p> <p>The 12/13/13 Hospital Transfer Report indicated the following:</p> <p>"Current Discharge Medication List START taking these medications...amoxicillin (antibiotic) 250 mg/5 mL suspension Commonly known as: AMOXIL Take 10 mls (500 mg total) by mouth every 8 (eight) hours for 7 days."</p> <p>The 12/13/13, 6:46 telephone order for Resident #160 indicated, "Amoxicillin Suspension Reconstituted 250 MG/5 ML Give 10 ml by mouth every 8 hours for infection for 7 Days"</p>						

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	<p>The 12/13/13, 8:18 p.m. nursing progress note indicated, "re-admitted from (name of hospital)...Medication verified by MD and fax to pharmacy."</p> <p>The December, 2013 MAR (medication administration record) indicated Resident #160 did not receive his first dose of the above antibiotic until 10:00 p.m. on 12/14/13.</p> <p>During an interview with the ADON (Assistant Director of Nursing) and DON (Director of Nursing) on 3/5/14 at 11:59 a.m. regarding Resident #160 not receiving his first dose of amoxicillin for over 24 hours after readmission to the facility. The DON indicated, "He came back with a UTI (urinary tract infection). We could have used amoxicillin from our EDK (emergency drug kit) if we didn't have his prescription in, but I don't see that we did that. They should have used the EDK. According to the MAR, 3 doses could have been given beginning at 10:00 p.m. on 10/13 (10/13/13). His face sheet says he arrived on 10/13 (10/13/13) at 4:36 (p.m.). The ADON indicated, "We also have a back up pharmacy we could have used." The ADON indicated it looked like the nurse who entered the medication into the computer entered the first dose as 10:00 p.m. on 10/14/14 instead of 6:00 a.m. on 10/14/14 because the computer made her skip the first dose due to the time the medication was entered.</p> <p>The Medication Reconciliation Guideline was provided by the DON on 3/5/14 at 1:07 p.m. It indicated the following:</p> <p>"Medication reconciliation is completed within 24 hours of admission. Information needed</p>			

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F000312 SS=D	<p>for medication reconciliation: Hospital Discharge orders or other transferring center's orders. (Name of facility) admission orders approved by admitting physician. A printed list of all of the medication orders from Point Click Care (PCC) (database). The nurse performing the Medication Reconciliation will compare each component of every Hospital Discharge Order with the corresponding handwritten admission orders to ensure that either:</p> <p>(1) The admission orders either include all of the hospital discharge orders or (2) There is documentation included in the admission orders that explains any changes."</p> <p>3.1-35(g)(2) 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interview and record review, the facility failed to ensure oral care was provided by nursing staff daily. This affected 1 of 3 residents reviewed of 5 who met the criteria for Activities of Daily Living (ADLs). (Resident #178)</p> <p>Findings include:</p> <p>The clinical record for Resident #178 was reviewed 3/4/14 at 11:30 a.m. The diagnoses for Resident #178 included, but were not limited to, debility, chronic thrombosis of deep veins of upper extremity, dysphasia, and renal failure. Resident #178</p>	F000312	<p>F312</p> <p>It is the practice of this facility that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #178 was given</p>	

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	<p>was admitted 2/17/14.</p> <p>During an interview with Resident #178, on 2/27/14 at 2:58 p.m., he indicated he had not received toothpaste or a toothbrush from the facility.</p> <p>A review of Resident #178's 14 day MDS (Minimum Data Set) Assessment, indicated Resident #178 had a BIMS (Brief Interview of Mental Status) of 12, which was indicative of mild cognitive deficit and interviewable. The MDS also indicated Resident needed extensive assistance with 2 person physical assist with personal hygiene.</p> <p>On 3/5/14, at 12:00 p.m., Resident #178 indicated he was unsure when his teeth had been brushed last, but it has been quite some time.</p> <p>During an interview with the Director of Nursing, on 3/5/14 at 1:00 p.m., she indicated there was no system in place to track if oral care was performed for a resident, so there was no way to ensure oral care was done daily.</p> <p>A policy titled, Residents' Rights, dated 10/09, received from the DoN on 3/3/14 at 10:28 a.m. It indicated, "...advocating that residents be groomed as they wish to be...."</p> <p>3.1-38(b)(1)</p>		<p>toothpaste and a toothbrush, and was assisted in brushing teeth.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents' rooms audited and residents given toothpaste and toothbrush when indicated. Audit of all resident's needing assistance with oral care conducted. All CNA assignment sheets updated to reflect individual residents needing assistance providing oral care.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>All nursing staff in-serviced on oral care. All residents given toothbrush and toothpaste upon admission. The presence of oral care supplies added to resident guardian angel room rounds.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p>	

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F000325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive		<p>The Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will observe oral care being performed on residents 3 times per week x 4 weeks, 2 times per week x 4 weeks, weekly x 4 weeks, then monthly. The Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will interview residents who are alert and oriented to ensure they are being assisted/receiving oral care 3 times per week x 4 weeks, 2 times per week x 4 weeks, weekly x 4 weeks, then monthly. Director of Nursing Services, Assistant Director of Nursing Services, and Unit Managers will inspect residents' oral mucosa/teeth of those residents unable to be interviewed to ensure oral care is being performed 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly x 4 weeks, then monthly. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>	

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	<p>assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on interview and record review, the facility failed to follow through with dietary recommendations for house shakes and assessment for edema and also failed to thoroughly evaluate significant weight changes for 2 of 3 residents reviewed of 11 who met the criteria for nutrition. (Resident #160 and #51)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #160 was reviewed on 3/3/14 at 11:32 a.m. He was admitted to the facility on 11/15/13. The diagnoses for Resident #160 included, but were not limited to, dysphagia.</p> <p>The weight in pounds for Resident #160 were as follows:</p> <p>11/16/13=161 11/26/13=168 12/16/13=137</p> <p>The 11/15/13 Clinical Health Status Admission Assessment indicated he was a nutritional risk due to swallowing problems and dietary restrictions.</p> <p>The 11/16/13 Nutrition Assessment indicated Resident #160's estimated nutrient needs</p>	F000325	<p>F325 It is the practice of this facility that, based on a resident's comprehensive assessment, the facility must ensure a resident maintains acceptable parameters of nutritional status, and receives a therapeutic diet when there is a nutritional problem. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows: Resident #160 no longer in facility. Resident #51 weighed with no edema present. How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows: Audit of all residents' monthly/weekly weights for discrepancies completed by Director of Nursing Services and Registered Dietitian with physician notification. All residents with suspected incorrect weights placed on weekly weights to ensure steady, stable weight. All resident's who indicate weigh loss audited for nutritional</p>	04/05/2014

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	<p>were 1830 - 2209 calories per day and 1830 - 2200 cc's of fluid per day.</p> <p>It indicated a nutrition diagnosis of "Inadequate Oral Intake". It indicated, "Inadequate oral intake as r/t (related to) dementia AEB (as exhibited by) intakes at meals 57% since admission." The nutrition goal was, "Resident will maintain current wt (weight) with gradual wt gain recommended." The summary indicated, "Residents current wt 161# BMI 23.1 (WNL) for age and ht (height). Diet is 2 gm mech (mechanical) soft NTL (no thin liquids) per MD orders. Resident is fed per staff and at times feeds self. Noted low meal intakes. Writer attempted to visit resident to update preferences d/t resident on a 2 gm diet and will not use selective menus. Resident did not respond to writer on several attempts at visiting. Noted residents with open area on coccyx. Labs reviewed. Recommend: house shake BID (twice daily) at lunch and dinner, document % consumed for wound healing and low meal intakes." This assessment was signed by the RD (Registered Dietician) on 11/21/13.</p> <p>Review of the November, 2013 MAR (medication administration record) indicated Resident #160 did not received house shakes BID.</p> <p>An interview was conducted with the ADON (Assistant Director of Nursing) and RD on 3/5/14 at 11:11 a.m. regarding Resident #160 not receiving the house shakes as recommended. The RD indicated, "I don't know why." The ADON indicated, "I don't see any information as to why house shakes was not implemented."</p> <p>The 11/27/13 IDT (Interdisciplinary Team)</p>		<p>supplements in place. What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows: All nursing staff in-serviced on the implemented weight program. Director of Nursing Services and Registered Dietitian will enter all monthly/weekly weights into PCC (nursing program for documentation) and Golden Living Center weight monitoring program. Residents determined to have noted weight gain/loss will be discussed in weekly weight management meeting. Registered Dietitian will give recommendations to Director of Nursing Services upon completion and Director of Nursing Services is responsible for ensuring completion of recommendations within 72 hours. How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: The Director of Nursing Services will audit weights weekly and monthly indefinitely. The Director of Nursing Services and Assistant Director of Nursing Services will audit all dietary recommendation within 72 hours after receiving recommendations indefinitely. Findings of the audits will be presented to the monthly Quality Assurance / Performance</p>	

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	<p>progress note indicated, "...intakes at meals 48%, decrease of 10% from previous weeks wt...IDT recommends: continue on weekly wts." The note does not address the recommendation for house shakes.</p> <p>The 12/16/13 Nutrition Assessment signed by the RD on 12/18/13 indicated, a nutrition diagnosis of inadequate oral intake. It indicated, "Inadequate oral intake as r/t dementia AEB intakes at meals 17% since re-admission (12/13/13). The summary indicated, Re-Admission assessment: Residents current wt 139# BMI 19.94 (under wt for age and ht). Resident has lost approx (approximately) 14% of wt in 30 d (30 days), from hosp (hospital) admission to facility readmission. Diet is mech soft NTL, intakes at meals low and do not meet residents est (estimated) needs. Writer visited resident concerning preferences for supplements, resident was awake when writer entered the room but did not respond to questions and then fell asleep. Resident previously with order for 2 gm NA diet, resident with low meal intakes, diet is not recommended at this time. Writer spoke with ST who recommended a diet downgrade from current mech soft NTL to puree NTL. Resident is fed per staff and at times feeds self...Recommend: house shake BID at lunch and dinner, document % consumed for wound healing and low meal intakes. Change diet to Puree NTL (per ST) and add NSP d/t heart disease."</p> <p>Review of the December, 2013 MAR (medication administration record) indicated Resident #160 did not received house shakes BID.</p>		<p>Improvement committee for further review and recommendations. By what date the systemic changes will be completed is as follows: 4/5/14.</p>	

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	<p>2. The clinical record for Resident #51 was reviewed 3/4/14 at 11:00 p.m. The diagnoses for Resident #51 included, but were not limited to, renal failure, diabetes mellitus, and congestive heart failure.</p> <p>A review of Resident #51's monthly weights indicated the following: 5/1/13=211 pounds 6/10/13=213 pounds 7/4/13=214 pounds 8/12/13=240 pounds 9/4/13=239 pounds.</p> <p>A Progress Note, dated 8/28/14, indicated, "RD (Registered Dietician) note for significant wt (weight) change: Residents [sic] monthly wt 240 # (pounds), likely inaccurate, resident refused to be weighed per nursing....Resident often does not take his dialysis book with him to dialysis, therefore no updated weigh [sic] available...."</p> <p>A Progress Note, dated 9/27/14, indicated, "RD note for significant wt change: Resident's monthly wt 239#. Resident has lost 0.42% in 30 d (days) and gained 12.21% in 90 d....Resident is weighed per lift, which could cause some wt inaccuracies, resident refused to be re-weighed for Aug 2013 d/t (due to) (symbol for greater than) 5# difference from July 2013 wt. IBWR (ideal body weight recommendation) 133-163#. Recommend: nursing staff check resident for edema."</p> <p>A policy titled, Weight Monitoring dated 2011, was received from the Director of Nursing (DoN), on 3/4/14 at 11:45 a.m. It indicated, "Each (name of corporation) will have a Nutrition Risk Committee. This committee should meet regularly to determine possible</p>			

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F000327 SS=D	<p>reasons for weight loss or gains...."</p> <p>During an interview with DoN, on 3/5/14 at 1:15 p.m., she indicated IDT (Interdisciplinary Team/Nutrition Risk Committee) should follow up with the significant weight loss/gain. The DoN further indicated the RD or IDT should communicate with the dialysis center to verify there was not a significant weight gain, especially since Resident #51 had a weight gain two months in a row. She also indicated staff should follow RD recommendations. The DoN indicated she will look into if IDT was notified/met regarding the weight gain and if the recommendation was followed up with.</p> <p>On 3/6/14, at 1:38 p.m., the Don indicated she was unable to locate any of the following information: IDT met regarding the above possible significant weight change, Follow up was done to ensure the weight was inaccurate, and the RD recommendation was followed through by nursing.</p> <p>3.1-46(a)(1) 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on interview and record review, the facility failed to encourage fluids to a resident to ensure adequate hydration resulting in a hospitalization for dehydration for 1 of 2 residents reviewed for dehydration. (Resident #160)</p>	F000327	<p>F327</p> <p>It is the practice of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>What corrective actions will be accomplished for those</p>	

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	<p>Findings include:</p> <p>1. The clinical record for Resident #160 was reviewed on 3/3/14 at 11:32 a.m. He was admitted to the facility on 11/15/13. The diagnoses for Resident #160 included, but were not limited to, dehydration and dysphasia.</p> <p>The 11/15/13 Clinical Health Status Admission Assessment indicated Resident #160 was at risk for dehydration due to dysphasia, use of diuretics or cardiovascular agents, and dependent on staff for provision of fluid intake.</p> <p>The 11/16/13 Nutrition Assessment indicated Resident #160's estimated nutrient needs were 1830 - 2209 calories per day and 1830 - 2200 cc's of fluid per day. It indicated a nutrition diagnosis of "Inadequate Oral Intake". It indicated, "Inadequate oral intake as r/t (related to) dementia AEB (as exhibited by) intakes at meals 57% since admission. The nutrition goal was, "Resident will maintain current wt (weight) with gradual wt gain recommended. The summary indicated, "Residents current wt 161# BMI 23.1 (WNL) for age and ht (height). Diet is 2 gm mech (mechanical) soft NTL (no thin liquids) per MD orders. Resident is fed per staff and at times feeds self. Noted low meal intakes. Writer attempted to visit resident to update preferences d/t resident on a 2 gm diet and will not use selective menus. Resident did not respond to writer on several attempts at visiting. Noted residents with open area on coccyx. Labs reviewed. Recommend: house shake BID (twice daily) at lunch and dinner, document % consumed for wound healing and low meal intakes." This</p>		<p>residents found to have been affected by the deficient practice are as follows:</p> <p>Resident #160 no longer in facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>All residents audited for poor oral intake using the group meal tab in Caretracker (CNA documentation system). Residents consuming less than 50% of meal intake over 7-day period assessed for dehydration, and encouraged fluid order with specific amounts, and volume consumed added to PCC (nursing documentation system).</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>All nursing staff in-serviced on dehydration. Nursing will document in PCC (nursing documentation system) all residents with decreased fluid intake. IDT will review nursing documentation daily and implement encouraged fluid order with specific amount and ml</p>	

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	<p>assessment was signed by the RD (Registered Dietician) on 11/21/13.</p> <p>Review of the November, 2013 MAR (medication administration record) indicated Resident #160 did not received house shakes BID.</p> <p>The I & O (Intake and Output) by Day Report indicated total intake in cc's for an 8 day period as follows:</p> <p>11/18/13=600 11/19/13=720 11/20/13=480 11/21/13=690 11/22/13=1020 11/23/13=840 11/24/13=660 11/25/13=300</p> <p>The 11/25/13 Hydration care plan indicated a potential for inadequate fluid intake as related to: requires thickened liquids, dementia, needs assistance for eating, history of infection. The goal was, "will be free from s/sx (signs/symptoms) of dehydration. An intervention was to assist with meals/eating as needed. The care plan did not indicate interventions to encourage fluids, acquire fluid preferences, involve family with meals, or to monitor intake.</p> <p>The 11/15/13, 7:19 p.m. nursing progress note indicated, "Resident is on a mechanical soft diet with thickened nectar liquids. Resident is a feed." This note did not indicate fluids were encouraged.</p> <p>The 11/16/13, 3:33 a.m. nursing progress note indicated, "Dysphasic." This note did not indicate fluids were encouraged.</p>		<p>consumed. This documentation will be reviewed by IDT daily and physician will be notified of any resident not consuming additional fluid. Direction to encourage fluids added to resident's at-risk for dehydration on CNA assignment sheet. Registered Dietitian recommendations to be completed within 48 hours of receipt. IDT will discuss residents at-risk for dehydration at weight management meeting for Registered Dietitian recommendations.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Nursing documentation related to fluid intake reviewed 5 times per week in daily morning meeting by IDT. Director of Nursing Services and Assistant Director of Nursing Services will report findings to monthly Quality Assurance / Performance Improvement committee for 6 months, discuss any patterns or trends, written action plans, and implemented interventions.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>				

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	<p>The 11/17/13, 12:43 p.m. nursing progress note indicated, "Dysphasic...Resident did allow staff to feed him today and appetite was good." This note did not indicate fluids were encouraged.</p> <p>The 11/17/13, 6:17 p.m. nursing progress note indicated, "dysphasic...Resident needs assistance with feeding and at times resident is capable of feeding self after setup..." This note did not indicate fluids were encouraged.</p> <p>The 11/18/13, 10:06 p.m. nursing progress note indicated, "Resident has dysphasia and is on mechanical soft with nectar thickened liquids. Resident requires assistance with feeds." This note did not indicate fluids were encouraged.</p> <p>The 11/19/13, 10:50 p.m. nursing progress note indicated, "resident requires assistance with feeds." This note did not indicate fluids were encouraged.</p> <p>The 11/20/13, 11:33 p.m. nursing progress note indicated, "Resident needs assistance with feeding and at times resident is capable of feeding self after setup." This note did not indicate fluids were encouraged.</p> <p>The 11/21/13, 11:14 p.m. nursing progress note indicated, "Resident requires assistance with feeds." This note did not indicate fluids were encouraged.</p> <p>The 11/22/13, 12:44 p.m. nursing progress note indicated, "Staff stated that he is easily distracted, for example if the TV is on he forgets to eat, and if he has more than one or two items of food in front of him he becomes too distracted to feed himself. Staff must</p>			

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	<p>supervise him while eating, offer him one item at a time, and help feed some of his meal to him (although he is physically able to feed himself), or he would not eat. Decision making severely impaired based on assessment." This note did not indicate fluids were encouraged.</p> <p>The 11/22/13, 3:41 p.m. Registered Dietician progress note indicated, "Resident was unable to voice food preferences to RD r/t 2 gm diet. Intakes at meals 58%. Recent RD recommendation for house shakes BID d/t low meal intakes..."</p> <p>The 11/27/13 IDT (Interdisciplinary Team) progress note indicated, "...intakes at meals 48%, decrease of 10% from previous weeks wt...IDT recommends: continue on weekly wts." The note does not address Resident #160's poor fluid consumption or the recommendation for house shakes or to encourage fluids.</p> <p>The 11/29/13, 10:40 p.m. nursing progress note indicated, "Resident showed minimal responsiveness on evening shift...Resident requires feeding by staff. Resident ate less than 25% of meal." This note did not indicate fluids were encouraged.</p> <p>The 11/30/13, 6:42 p.m. nursing progress note indicated, "Resident declined his medication, would not open eyes to take medication. MD has been notified."</p> <p>The 11/30/13, 6:45 p.m. nursing progress note indicated, "Resident would not open mouth to take medication. MD was notified."</p> <p>The 11/30/13, 7:13 p.m. nursing progress note indicated, "Resident has been sleeping</p>			

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	<p>majority of the shift. Resident would not wake up to take eve (evening medication. MD stated that resident does this on and off and spouse says that he has been sleeping a lot..."</p> <p>The 12/1/13, 2:13 p.m. nursing progress note indicated, "Change of Condition...Situation: Resident continues to not want to eat or drink. Resident will not open his eyes today and has been resistive to staff...Assessment: Resident continues to not want to eat or drink and holds his lips shut when you try to feed him or give him his medicine. Resident started having some diarrhea this afternoon...Response: (name of doctor) contacted and orders received to send resident to the hospital for evaluation. Residents wife here and aware of the orders..."</p> <p>The 12/13/13 Physician Discharge Summary from the hospital indicated,</p> <p>"Discharge Diagnoses: Patient Active Problem List Diagnosis Hypernatremia Hypokalemia Dehydration..."</p> <p>Lab Results...collected: 12/1/13, 1600...Sodium 152 (H), Chloride 115 (H), Glucose 126 (H), BUN 58 (H)..." Normal sodium levels are 135-145. Normal chloride levels are 95-105. Normal glucose levels are below 125. Normal BUN is 7-20.</p> <p>During an interview with the ADON and RD on 3/5/14 at 11:11 a.m. regarding any recommendations or interventions after the 8 days of tracking the low fluid intake and the</p>			

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	<p>house shakes recommendation not being followed through upon, the RD stated, "I don't see that I made any recommendations after (8 days of fluid intake tracking)." Regarding whether she was aware of the low fluid consumption, she indicated, "I was probably informed in morning meeting of low intake, but I don't remember discussing it specifically." The ADON indicated she didn't recall discussing it either. She further indicated there was no good reason for not addressing the low fluid intake around 11/25/13, after the intake tracking ended. She stated, "I truly don't remember going over this at morning meeting. Usually we would discuss it and have the unit manager follow up with the MD about it. The 11/25 (11/25/13) progress note addresses not eating and low stats, but not the hydration. I don't see any info as to why house shakes was not implemented on 11/16 (11/16/13) or why boost was on 12/20.</p> <p>During an interview with the DON and Rehabilitation Unit Coordinator on 3/6/14 at 12:07 p.m. regarding lack of encouragement of fluids for Resident #160, the DON indicated, "There was no order for it." The Unit Manager indicated, "I don't remember encouraging CNA's to offer him fluids between meals.</p> <p>Regarding whether family was encouraged to participate in feeding at meals, the Unit Manager indicated, "I don't remember having a specific conversation with family about encouraging him to drink." Regarding whether drink preferences were ever acquired for Resident #160, the Unit Manager indicated, "I don't recall a specific conversation with his wife about what his preferences were." Regarding the 11/27/13 IDT meeting and whether fluid consumption</p>			

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F000329 SS=D	<p>was discussed, the Unit Manager indicated, "I go to meetings, and I don't remember specifically discussing his lack of fluid consumption. It doesn't stick out in my mind that he was having a fluid problem." The DON indicated there was no hydration policy for nursing.</p> <p>During an interview with Resident #160's doctor on 3/6/14 at 12:35 p.m., she indicated she knew he was a hydration risk and she thought "he was holding his own until they called me (on 12/1/13)."</p> <p>During an interview with the DON on 3/6/14 at 3:20 p.m. regarding what was done after the 8 days of low fluid intake records, she stated, "After the 7 days of intakes, we would come up with a specialized plan of care to address the low fluid intake...I don't see where we did that with (name of Resident #160)."</p> <p>During an interview with the Administrator on 3/6/14 at 3:25 p.m. regarding Resident #160's hydration situation, he stated, "I think (name of Resident #160) was the 'one off.' I don't know how we missed him."</p> <p>3.1-46(b) 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</p>			

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	<p>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 interview and record review, the facility failed to follow physician's orders to properly monitor PT/INR (blood clotting lab) for a Resident on an anticoagulant and failed to monitor behaviors for a Resident on an anti-psychotic. This affected 2 of 5 residents reviewed for unnecessary medications. (Residents #178 and #175)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #178 was reviewed 3/4/14 at 11:30 a.m. The diagnoses for Resident #178 included, but were not limited to, debility, chronic thrombosis of deep veins of upper extremity, dysphasia, and renal failure.</p> <p>A review of the February Physician's Orders indicated an order for PT/INR (blood clotting test) on Mondays and Thursdays weekly starting on 2/13/14.</p> <p>A review of the PT/INRs for Resident #178 indicated the following dates/values: 2/13/14=PT-17.2, INR-1.6,</p>	F000329	<p>F329</p> <p>It is the practice of this facility that each resident's drug regimen be free from unnecessary drugs.</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice are as follows:</p> <p>PT/INR obtained for resident #178. Antecedent log per behavior management guidelines started for resident #175.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows:</p> <p>Audit of all residents receiving PT/INRs for month of March audited. Physician notified of any</p>	04/05/2014

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	<p>2/17/14=PT-19.3, INR-1.8, 2/20/14=PT-24.3, INR-2.2, & 2/27/14=PT-17.4, INR-1.6.</p> <p>The (name of lab company) lab sheets indicated standard anticoagulant values for INR was 2.0-3.0.</p> <p>The February Physician's Orders indicated a change of order for warfarin from 3 milligrams (mg) on Sunday, Tuesday, Thursday, Saturday and 4 mg on Monday, Wednesday, and Friday to 4 mg daily after the 2/27/14 PT/INR lab draw.</p> <p>The Nursing Spectrum Drug Handbook, copyright 2010, indicated, "Warfain....FDA Boxed Warning, Drug may cause major or fatal bleeding....Monitor INR regularly in all patients...."</p> <p>On 3/5/14, at 11:00 a.m., the Director of Nursing (DoN) indicated the missing PT/INR lab for 2/25/14 was not done, as ordered. The DoN indicated, she audited the Resident's clinical record after the Resident had a fall and that was when she noticed the 2/25/14 PT/INR lab was not done.</p> <p>2. The clinical record for Resident #175 was reviewed 3/3/14 at 1:45 p.m. The diagnoses for Resident #175 included, but were not limited to, metabolic encephalopathy, depression, psychosis, and chronic systolic heart failure.</p> <p>A Progress Note, dated 2/13/14, indicated, "I had spoke with wife [sic] earlier today and she expressed that she wanted something to help resident [sic] with his behaviors that are potentially harmful to self. I called and spoke with MD (Medical Doctor). Orders for Seroquel given...."</p>		<p>missing PT/INRs. Audit of all residents receiving antipsychotic medication completed, verifying that antecedent log tracking sheet present and current with corresponding care plan.</p> <p>What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows:</p> <p>All licensed nursing staff in-serviced on Oral Anticoagulant Therapy Guideline and Behavior Management Guideline. All orders will be reviewed in daily morning meeting. Director of Nursing Services and Assistant Director of Nursing Services will ensure PT/INR flowsheet implemented for all residents with new order for coumadin therapy. Social Service Director and Social Service Assistant will ensure antecedent behavior tracking log implemented with new antipsychotic medication use. Behavior care plans will be updated by Social Services.</p> <p>How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following:</p> <p>Director of Nursing Services and</p>				

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	<p>A Telephone Order, dated 2/13/14, indicated an order for Seroquel 25 mg to be taken at bedtime daily.</p> <p>A policy titled Behavior Management Guideline, dated 2013, was received from the Director of Nursing (DoN), on 3/6/14 at 1:20 p.m. It indicated, "Antipsychotic drug use is evaluated by the prescriber and the behavior management team within 7 days drug initiation or admission with drug order....The Antecedent Behavior Monitoring Log is utilized for new residents with behaviors and current residents who exhibit new behaviors that negatively impact functioning or quality of life. The log is reviewed by the Behavior Committee members to identify patterns and causative or triggering events for the behavior(s) and effectiveness of interventions....Based on a review of the tracking log, a determination will be made if the resident is a danger to self or others and if so, a plan of care is developed to ensure safety...."</p> <p>A document titled, Behavior Management Committee, dated 2013, was received from the DoN, on 3/6/14 at 1:20 p.m. It indicated, "The focus of Behavior Management Committee is to conduct an interdisciplinary review, analysis and if warranted, revision or creations [sic] of a behavior management plan both behavioral and pharmacological....The Committee reviews:...2. Review of Care Tracker Mood and Behavior Report from care tracker [sic]."</p> <p>The Nursing Spectrum Drug Handbook, copyright 2010, indicated, "quetiapine fumarate (Seroquel)...FDA Boxed Warning...With patient of any age, observe</p>		<p>Assistant Director of Nursing Services will audit PT/INR tracking logs and Social Services will audit antecedent behavior monitoring logs and care plans of affected residents (those on coumadin and those receiving antipsychotic medication) 3 times per week for 4 weeks, 2 times per week for 4 weeks, weekly x 4 weeks, then monthly. Findings of the audits will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations.</p> <p>By what date the systemic changes will be completed is as follows:</p> <p>4/5/14.</p>	

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F000441 SS=D	<p>closely for clinical worsening, suicidally, and unusual behavior changes when therapy begins...."</p> <p>During an interview with the DoN, on 3/5/14 at 2:45 p.m., she indicated all residents on an antipsychotic medication should have behavior tracking/monitoring to ensure the medication is needed and beneficial to the Resident. The DoN also indicated the IDT (Interdisciplinary Team/Behavior Management Committee) should be monitoring a Resident's behavior, if they were on an antipsychotic. The behavior tracking/monitoring and IDT notes were requested at this time.</p> <p>On 3/6/14, at 1:45 p.m., the DoN indicated she was unable to locate any behavior monitoring/tracking or IDT documentation for Resident #175.</p> <p>A behavior care plan, dated 2/17/14, for depression, psychosis, and hallucinations was reviewed. Behavior monitoring/tracking was not noted as an intervention on the care plan.</p> <p>At 1:58 p.m., on 3/6/14, the DoN indicated behavior monitoring/tracking should be part of a behavior care plan.</p> <p>3.1-48(a)(3) 3.1-48(b)(2) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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</p>			

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	<p>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>Based on observation, interview, and record review, the facility failed to properly sanitize the West Wing glucometer (machine used for readings of blood glucose/sugar levels) during a random observation. This affected 2 of 6 residents that require glucometer readings on West Wing. (Resident #47 and #41)</p>	F000441	F441 It is the practice of this facility to 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. What corrective actions will be accomplished	04/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155076	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/06/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER- BROOKVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 7145 E 21ST ST INDIANAPOLIS, IN 46219
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	<p>Findings include:</p> <p>1. During a random observation of blood glucose testing for Resident #47, with RN #5 on 3/4/14 at 4:21 p.m., RN #5 wiped the glucometer with (Name of Company) Healthcare Bleach Germicidal Wipes for approximately 14 seconds before performing the blood glucose testing. After the blood glucose testing was performed, RN #5 wiped the glucometer with (Name of Company) Healthcare Bleach Germicidal Wipes for approximately 15 seconds and then placed the glucometer in the medication cart.</p> <p>During an interview with RN #4, on 3/4/14 at 4:30 p.m., she indicated the glucometer above was used for all the Residents on West Wing that required blood glucose testing.</p> <p>A review of the label on the container for the (Name of Company) Healthcare Bleach Germicidal Wipes, indicated the wipes were to be used for 1 minute to decontaminate an object, of viruses/bloodborne pathogens.</p> <p>2. On 3/4/14, at 4:40 p.m., RN #5 pulled out the above glucometer from the medication cart, to perform blood glucose testing on Resident #41. There was continuous observation of RN #5 and the medication cart from the observation above to 4:40 p.m. RN #5 went into Resident #41's room and set the glucometer on the bedside table, without wiping the glucometer with the above wipes. RN #5 proceeded to prepare the glucometer for blood glucose testing, by placing the blood glucose testing strip into the glucometer and wiping Resident #41's finger with an alcohol pad. RN #5 picked up the</p>		<p>for those residents found to have been affected by the deficient practice are as follows: Resident #47 blood glucose level was obtained. RN #5 in-serviced on the blood glucose monitoring decontamination policy. How other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions will be taken are as follows: All residents receiving blood glucose monitoring identified. Physician notified of deficient practice. Residents reviewed with no adverse outcomes noted. What measures will be put into place and the systemic changes will be made to ensure that this deficient practice does not recur are as follows: All licensed nursing staff will be in-serviced to glucometer decontamination policy and return/demonstrate proper cleaning of the machine. How the corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: The Director of Nursing Services, Assistant Director of Nursing Services, and Director of Clinical Education will observe licensed nursing staff properly clean the glucometer and perform glucometer testing</p>	

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	<p>blood glucose needle to obtain a sample of blood and was holding Resident #41's finger out to be pricked by the needle. RN #5 was stopped from pricking Resident #41 finger.</p> <p>On 3/4/14, at 4:47 p.m., RN #5 indicated she was unsure of how long she wiped the glucometer after she performed the blood glucose testing on the previous resident. Then RN #5 proceeded to wipe the glucometer with the (Name of Company) Healthcare Bleach Germicidal Wipes for 1 minute.</p> <p>The Administrator provided a list, titled West Accuchecks B/S (Blood Sugar), on 3/5/14 at 1:41 p.m. The list had 6 residents on it that required blood glucose testing, on West Wing.</p> <p>At 2:00 p.m., on 3/5/14, the Director of Nursing indicated the glucometers should be wiped with (Name of Company) Healthcare Bleach Germicidal Wipes for 1 minute, after each resident use.</p> <p>During an interview, on 3/6/14 at 10:50 a.m. the Director of Nursing indicated there was no policy in regards on how long to wipe the glucometer with the (Name of Company) Healthcare Bleach Germicidal Wipes.</p> <p>3.1-18(a)</p>		<p>on residents receiving blood glucose monitoring 5 times per week x 4 weeks, 3 times per week x 4 weeks, 2 times per week x 4 weeks, then monthly. All inaccurate cleaning/testing visualized will be immediately addressed by observer with action taken, including disciplinary. Findings of the observations will be presented to the monthly Quality Assurance / Performance Improvement committee for further review and recommendations. By what date the systemic changes will be completed is as follows: 4/5/14.</p>	