

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/24/2014
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NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR AVON, IN 46123
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00159345.</p> <p>Survey Dates: November 17, 18, 19, 20, 21, and 24, 2014</p> <p>Facility Number: 000141 Provider Number: 155236 AIM Number: 100283860</p> <p>Survey Team: Kewanna Gordon RN-TC Lora Brettnacher RN Megan Burgess RN Tracina Moody RN (November 24, 2014)</p> <p>Census bed type: SNF/NF: 124 Total: 124</p> <p>Census payor type: Medicare: 20 Medicaid: 72 Private: 11 Other: 21 Total: 124</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC</p>	F000000	<p><i>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and continue to provide quality care.</i></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000242 SS=D	<p>16.2-3.1.</p> <p>Quality review completed 12/2/14 by Brenda Marshall, RN</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents' choices were honored regarding their preferences for frequency of showers for 1 of 3 residents reviewed who met the criteria for choices (Residents #9).</p> <p>Findings include:</p> <p>During an interview on 11/18/14 at 1:14 p.m., Resident #9 indicated he did not get to choose how many times a week he took a shower. He indicated he would take one every day if they let him but usually he was given one or two a week.</p> <p>Resident #9's record was reviewed on 11/20/14 at 10:43 a.m. A Minimum Data</p>	F000242	<p>The facility requests paper compliance for this citation. <i>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and continue to provide quality care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i> Resident #9 was interviewed and choice questionnaire sheet was updated with resident's bathing preference as far as type and frequency. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents will be interviewed</p>	12/24/2014			

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	<p>Set (MDS) assessment tool, dated 9/16/14, indicated Resident #9 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 and required physical assistance from staff for bathing.</p> <p>A document titled "Choices for Resident Care," dated 11/16/14, indicated Resident #9 indicated to the facility staff two showers a week were not acceptable to him. He preferred three showers a week and he preferred them in the morning.</p> <p>Resident #9's "Showers/Bathing" records for November 2014, were reviewed. The records indicated from 11/6/14 through 11/20/14, (15 days) Resident #9 received two showers. He received a shower on 11/10, and on 11/15. The record indicated Resident #9 refused/was not available for his shower.</p> <p>During an interview on 11/24/14 at 9:45 a.m., the Director of Nursing (DON) indicated she had spoken with the Certified Nursing Assistants who usually took care of Resident #9 and they reported to her he did not have a history of refusing care. She indicated she did not have an explanation as to why Resident #9 had not been provided his preference regarding frequency of showers.</p>		<p>to review resident choices and any changes will be noted on care sheet and care plan. All other resident choice forms will be reviewed quarterly with care plan meeting and as needed with resident initiated choices change.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All staff inserviced on resident rights and choices (in particular to bathing type and frequency), and to report any resident requests to change choices to social services and/or nurse management. Policy will be followed on resident choices:</p> <ul style="list-style-type: none"> · Questionnaire will be completed on admission, readmission, quarterly and as needed. · The questionnaire will be discussed in the clinical morning meeting the next business day following the completion of the questionnaire and resident choices will be implemented and care planned. · Resident choices will be reviewed during quarterly care plan reviews and as needed. · CNA care sheets will be updated with resident choices. · The questionnaires will be maintained in a binder. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p>		

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F000272 SS=D	<p>A policy titled "Resident Choices" identified as current by the Executive Director on 11/24/14 at 2:10 p.m., indicated, "...To ensure that resident choices are honored in regards to provided resident centered care... An interview with the resident/responsible party will be conducted on the next business day after admission... The facility normal practices will be explained to the resident. The questions will allow the resident to choose times and situations that are acceptable to them... The facility will honor the specific resident choices...The questionnaire will be discussed in the clinical morning meeting the next business day following the completion of the questionnaire and resident choices will be implemented and care planned...."</p> <p>3.1-3(u)(3)</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information;</p>		<p>3 resident choice forms will be compared to resident bathing offered for accuracy in care provided weekly and documented on audit form. Audit tool will be done weekly times 4, then monthly times 2, then quarterly times 1 and reviewed in Monthly QA meetings. Further auditing will be determined by QA. Who will oversee the program: DON/Designee</p>				

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	<p>Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continenence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on record review and interview, the facility failed to ensure accuracy of a comprehensive assessment for 1 of 3 residents reviewed for Minimum Data Assessment (MDS) accuracy regarding dental status (Resident #175).</p> <p>Findings include:</p> <p>On 11/19/2014 at 11:01 a.m., Resident #175 was observed to have a loose lower denture that slipped when she spoke.</p> <p>Section L of Resident # 175 's Minimum</p>	F000272	<p>The facility requests paper compliance for this citation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #175 had a new oral/dental assessment completed and concerns addressed with dentist. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents will have an oral/dental assessment completed and any concerns found will be noted on resident care plan and referral to</p>	12/24/2014	

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	<p>Data Set assessment (MDS), dated 10/7/2014, indicated the resident did not have any problems related to dental status including but not limited to, broken or loosely fitting full or partial dentures.</p> <p>A progress note, dated 9/29/14, indicated Resident #175 had been seen by the dentist and had loose lower dentures.</p> <p>During an interview on 11/20/2014 at 11:20 a.m., the MDS Coordinator indicated, the tools used to assess dental status for residents included, but were not limited to, observation of the residents and the residents dental appointment notes. He further indicated the dental records, dated 9/29/2014, for Resident #175 had not been reviewed when completing the 10/7/2014 MDS comprehensive assessment.</p> <p>A policy and procedure regarding MDS's was requested from the Executive Director on 11/24/2014. He indicated that he did not have a policy and procedure to provide. He indicated the facility used the Resident Assessment Instrument (RAI) as a guideline for the completing the MDS assessments.</p> <p>3.1-31(9)</p>		<p>dentist if indicated. All MDS assessments completed in last 7 days will be reviewed with oral/dental assessments for accuracy and modified if needed.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All staff inserviced on reporting any changes in chewing ability, improper fitting dentures, and complaint of mouth pain to Charge Nurse who will refer resident to Social Services as needed for Dental services. Licensed nurses inserviced on importance of accurate oral/dental assessments and reporting of any changes or concerns to Nurse Management.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Weekly, 3 residents in MDS assessment period will have random oral checks compared to oral/dental assessment completed that period for accuracy. Results will be placed on an audit tool. Audit tool will be completed weekly times 4; monthly times 2; and quarterly times 1 and reviewed in Monthly QA meetings. Further auditing will be determined by QA. Who will oversee the program: DON/Designee</p>		

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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> <p>Based on record review and interview, the facility failed ensure a comprehensive care plan was developed for 1 of 3 residents reviewed for care plans related to unnecessary medications. (Resident #175).</p> <p>Findings include:</p> <p>1. On 11/20/2014 at 10:05 a.m., Resident #175 's record was reviewed. Her diagnosis included, but was not limited to, long term anticoagulant use. The Minimum Data Set (MDS), dated</p>	F000279	<p>The facility requests paper compliance for this citation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #175 has a care plan in place for use of Coumadin How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents on Coumadin have had their care plans reviewed for development of Coumadin Care Plan and developed if not in place. What</p>	12/24/2014	

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F000325 SS=D	<p>10/1/2014, indicated the resident received anticoagulant therapy; however this was not reflected in the plan of care for the resident.</p> <p>A review of Resident #175 ' s medications indicated she received Coumadin (anticoagulant) 3 mg daily.</p> <p>During an interview on 11/24/14 at 12:40 p.m., the MDS Coordinator indicated a care plan related to anticoagulants should have been initiated upon admission for Resident #175 but this had not been done.</p> <p>A policy titled "Care Plans Protocol," identified as current by the Executive Director on 11/24/14 at 2:04 a.m., indicated, "...Care plans are to be reviewed and updated by each discipline ... The care plan should be revised on an on-going basis to reflect changes in the resident and the care the resident is receiving... Acute changes and order changes should be addressed on the care plan"</p> <p>3.1-35(b)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a</p>		<p>measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All licensed nursing staff will be inserviced on developing care plans for all residents on Coumadin therapy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: An audit will be completed in Clinical Meeting when new Coumadin initiated orders are obtained for residents to check for appropriate Care Plans in place. Results of audits will be reviewed in QA monthly times 3; then quarterly times 1. Further monitoring will be determined by QA. Who will oversee the program: DON/Designee</p>		

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	<p>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 ensure a system which monitored consumption of fortified foods to ensure its efficacy to prevent weight loss for 1 of 3 residents who triggered for nutritional status (Resident #9).</p> <p>Findings include:</p> <p>Resident #9's record was reviewed on 11/20/14 at 10:43 a.m. A Minimum Data Set (MDS) assessment tool, dated 9/16/14, indicated Resident #9 had a Brief Interview for Mental Status (BIMS) score of 9 out of 15.</p> <p>A dietary note, dated 9/16/14 at 4:24 p.m., indicated, "Quarterly review: Resident receives a regular diet per MD order. In addition to meals, receives super cereal at breakfast, whole milk with meals, 1/2 sandwich and 8 oz [ounces] beverage at pm [evening] snack. Tolerates diet with no chewing/swallowing problems noted. Per consumption records; acceptance of</p>	F000325	<p>The facility requests paper compliance for this citation.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #9 is a hospice resident and has requested not to be weighed monthly unless he is physically able due to discomfort of procedure. Resident is also on regular diet. Resident does receive "super cereal" which will be added to MAR for nurse to document the amount resident consumed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Super cereal is the only "fortified" food recommended by Dietician and to be monitored. Residents receiving fortified "super cereal" has task entered on MAR to trigger nurse to document the amount/percentage of cereal resident consumes. What measures will be put into place or what systemic changes you will make to ensure that the deficient</p>	12/24/2014

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	<p>diet daily average is 51-75% of meals and 823 ml daily average fluid intake...."</p> <p>A document titled "Avon Health and Rehabilitation Center Weights and Vitals Summary" indicated on September 16, 2014, Resident #9 weighed 203.6 lbs. On September 23, 2014 (seven days after the addition of fortified foods to his diet), Resident #9 weighed 209.6 pounds (a gain of six pounds). This document indicated on Oct 2, 2014, Resident #9's weighed 206.4 (a loss of 3.2 pounds).</p> <p>A dietary note, dated 10/10/14 at 4:44 p.m., indicated, "Weight Review: BMI 31.4 above recommended range, 206.4# [pounds] Resident has orders for hospice eval [evaluation] and treatment. Weight has had gradual decline, but not significant. Regular diet with thin liquids provided, per data at nutritional risk due to decline in PO [oral] intakes averaging 44-53% since September. Added calories offered via whole milk and juice with meals. Super cereal at breakfast. 1/2 sandwich and beverage at HS [bedtime]. Skin ok. No edema reported. Suggest 1/2 sandwich and beverage at HS increased to 1 whole sandwich and beverage.</p> <p>A document titled "Avon Health and Rehabilitation Center Weights and Vitals</p>		<p>practice does not recur: All nursing staff will be inserviced on the importance of documenting the intake of "super cereal" on residents receiving it as noted on meal ticket. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>RD will review resident acceptance task for residents receiving "super cereal" during NAR meeting and note any concerns in RD report. This will be reviewed monthly in QA times 6 months. Further monitoring will be determined by QA. Information will be documented on an audit tool. The audit tool will be done in NAR weekly times 4; monthly times 2 and quarterly times 1. Further monitoring will be determined by QA. Who will oversee the program: RD/Designee will oversee program</p>		

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F000371	<p>Summary" indicated Resident #9 was re-weighed on November 6, 2014 and weight was 203.4 pounds. The record did not indicate weights were monitored for 27 days after the dietician documented a nutritional risk due to declined oral intake.</p> <p>Resident #9's meal consumption records, dated 10/16/14 through 11/2014, were reviewed. These records indicated Resident #9 consumed 0-25% for 35 out of 85 (41%) meals served during this time.</p> <p>During an interview on 11/24/14 at 9:45 a.m., the Director of Nursing (DON) indicated she was unsure if the facility had a system to monitor residents received and/or the consumption of fortified foods provided to prevent weight loss.</p> <p>During an interview on 11/24/14 at 10:30 a.m., with the DON and a Corporate Consultant present, the Corporate Consultant indicated the facility's system to monitor the effectiveness of fortified foods as an intervention for weight loss was by "weighing the residents."</p> <p>3.1-46(a) 483.35(i)</p>						

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SS=E	<p>FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure adequate hand sanitation while providing feeding assistance to three residents for 1 of 2 observations in 1 of 6 (Restorative) dining rooms (Residents #6, #37, #92). Findings include: On 11/17/2014 from 12:46 p.m. to 1:01 p.m., during the lunch dining observation, Certified Nursing Assistant (CNA) #1 removed Resident #6's foot pedal from her wheel chair. Without washing her hands after removal of Resident #6's wheel chair pedal, CNA #1 was observed to serve Resident #6 a spoonful of food with her right hand. Next, she removed Resident #92's straw from its wrapper, by holding the straw with her right bare hand, and then inserted the straw into Resident #92's drink. As CNA #1 continued to assist with feeding, she was observed to rest her right hand on Resident #6's arm before she offered Resident #37 a spoonful of</p>	F000371	<p>The facility requests paper compliance for this citation. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Unable to correct the activity that occurred in the past. No negative side effects have been noted in the identified residents from cited activity. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: No other residents or meal service dining areas were identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: All staff inserviced on proper hand washing policy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: A meal service audit will be completed on 5 staff members in varying dining rooms and shifts</p>	12/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155236		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/24/2014	
NAME OF PROVIDER OR SUPPLIER AVON HEALTH & REHABILITATION CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 4171 FOREST POINTE CIR AVON, IN 46123			
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	<p>food with her right hand. She was then observed to wipe Resident #6's mouth with her clothing protector with both hands before she offered Resident #37 a spoonful of food with her right hand.</p> <p>During an interview on 11/24/2014 at 9:48 a.m., the DON (Director of Nursing) indicated staff should have washed their hands after a resident or wheelchair equipment was touched and before assistance with meals was provided to residents.</p> <p>During an interview on 11/24/2014 at 1:34 p.m., CNA #1 indicated staff should have washed their hands after a resident was touched and before feeding assistance was provided to a different resident.</p> <p>A policy titled "Hand Washing" identified as current by the Executive Director (ED) on 11/21/2014 at 9:00 a.m., indicated, "To Ensure proper hand washing before and after procedures and/or resident to prevent the spread of infection... When to Wash Hands (at a minimum)... After touching resident or handling his or her belongings, before and after each resident contact..."</p> <p>3.1-21(i)(3)</p>		<p>weekly. Audits will be reviewed in Monthly QA times 6 months. Further monitoring will be determined by QA. Who will oversee the program: DON/Designee</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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