

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2012
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NAME OF PROVIDER OR SUPPLIER CHASE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2 CHASE PARK LOGANSPORT, IN 46947
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: November 26, 27, 28, 29, 30, 2012.</p> <p>Facility identifier listing: Facility number: 000021 Provider number: 155710 AIM number: 100275270</p> <p>Survey team: Tim Long, RN, TC Julie Wagoner, RN Christine Fodrea, RN</p> <p>Census bed type: SNF: 3 SNF/NF: 74 Total: 77</p> <p>Census Payor type: Medicare: 9 Medicaid: 58 Other: 10 Total: 77</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	Chase Center (the Provider) submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. The submission of the PoC does not indicate an admission by Chase Center that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Chase Center. This PoC shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is submitted as a matter of statute only.	

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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F0156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</p>			

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	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interviews, the facility failed to ensure a liability and notice of appeal was issued to 2 of 3 residents who met the criteria and who were discharged from Medicare services. (Residents # 98 and 104)</p> <p>Findings include:</p> <p>The electronic clinical records for discharged Residents #98 and 104 were reviewed on 11/28/12 at 2:45 P.M. The Social Services Director, Employee #12 was asked to provide the notice of liability and appeal rights form for both residents. Employee #12 indicated both residents had been discharged to their private homes and did not need to have been issued the liability and appeal rights form as they were set up to continue</p>	F0156	<p>1. Corrective Action All residents being discharged will receive a liability and appeal right form (SNFABN) See Exhibit A This will be completed with the resident and/or responsible party. 2. Potential to affect other residents This policy will be implemented by all residents who will be discontinuing from Medicare A services.3. Systemic changes The ABN will be issued to all residents regardless of the Medicare A discharge status, i.e. remain in facility, return home, etc.4. Corrective Action to Monitor Began process during survey, and will monitor the ABN's in the daily Manager Meeting.ADDENDUM: F156, F159The Social Service Director is responsible to issue the ABN letter and will report compliance progress to the QA Committee monthly. The frequency of monitoring will be every resident</p>	12/14/2012	

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	<p>receive outpatient therapy once they were in their own homes.</p> <p>Interview with the Administrator, on 11/29/12 at 9:20 A.M., indicated both residents, who had received Medicare Part A services and were discharged to their homes, were not provided with the liability and appeal rights form as required. She indicated the facility had erroneously thought if a resident was being discharged to their home, the form did not need to be issued.</p> <p>3.1-4(a)</p>		<p>with Medicare A. See Exhibit SS-1. The SSD will report compliance progress, and if 100% compliance is achieved within six (6) months, it will no longer be monitored by the QA Committee.</p>		

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review the facility failed to notify the physician of a significant weight loss for 1 of 3 residents reviewed for</p>	F0157	1. Corrective ActionThe physician was notified on 11/15/2012 and an order for a supplement was received for resident #71. In addition, the Nursing Unit Manager will review	12/28/2012

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	<p>physician notification. (Resident #71)</p> <p>Findings include:</p> <p>Resident #71's record was reviewed 11-28-2012 at 10:39 A.M.. Resident #71's diagnoses included but were not limited to: malignant colon cancer, high cholesterol, gout, anemia, dementia, depression, heart disease, pulmonary hypertension, congestive heart failure, Barrett's esophagus, osteoarthritis, and adult failure to thrive.</p> <p>Resident #71's weight on 9-21-2012 was 141; on 10-18-2012, her weight was 138, a 2.1% weight loss; on 11-1-2012, her weight was 129, an 8.5% weight loss.</p> <p>A dietary assessment dated 9-25-2012 indicated swallowing was a concern, but no interventions were noted to address possible weight concern related to diagnoses of cancer and anemia. Adult failure to thrive was not added as a diagnosis at that time.</p> <p>A nutritional assessment dated 9-25-2012 indicated intakes were 75-100% of meals. The assessment further indicated refusal to wear dentures, and diagnosis of cancer</p>		<p>for significant weight changes, and will ensure the physician is notified promptly.2. Other Residents having a Potential concernThe Dietitian along with the Nursing Unit Manager will review resident weights and all RD recommendations will be followed to include physician notification. All RD recommendations will be discussed and documentation of interventions will be made. The RD visits weekly and will follow up from the previous week's notes with the Nursing Unit Manager or designee.3. Systemic ChangesThe RD visit notes will be discussed with the Nursing Unit Manager, who will follow up with physician notification. The Dietary Manager is also responsible to monitor compliance. A nursing inservice will be scheduled to address this issue.4. Monitor of Corrective ActionThe Dietary Manager will present the RD recommendations to the Nursing Unit Manager, who will report compliance to the QA Committee monthly. This goal has been added to the QA Committee function (Refer to Exhibit ??) The goal was presented to the QA Committee at its 12/12/2012 meeting.</p> <p>ADDENDUM: F157Please refer to Exhibit B1 & B2 for the QA Committee Policy. The RD will present a compliance report to the monthly QA Committee and monitoring will be ongoing. See</p>				

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	<p>and swallowing difficulty. The assessment indicated Resident #71 was at moderate risk for loss. Resident #71's needs and preferences were reviewed. The recommendation was the facility was to send soft foods for her to eat as an intervention.</p> <p>Resident #71's intake declined between 10-3-2012 and 10-15-2012 according to the nutritional assessment dated 10-15-2012. The assessment indicated intakes dipped to 25-75% and Resident #71's weight began to decline 10-15-2012. There is no note the dietician was notified and no note the physician was notified.</p> <p>A nutritional assessment dated 11-15-2012, indicated Resident #71's weight had declined to 128. There was still no note of dietician or physician notification.</p> <p>Dietary notes dated 10-26-2012 indicated weight decline and intakes decline to about 50%, but noted Resident #71's appetite had increased in recent days. The notes indicated intervention was to send health shakes.</p> <p>In an interview on 11-28-2012, the</p>		Exhibit RD-1. The goal will be established at 100%.				

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	<p>Minimum Data Set assessment coordinator indicated Resident #71 had edema, so some weight loss was expected and no MD or family notification was noted in the record regarding weight loss.</p> <p>According to a physician's order summary dated 11-2012, health shakes were not added until 11-15-2012. A review of discontinued physician's orders indicated no other supplement had been ordered prior to the 11-15-2012 order. The 11-15-2012 order indicated the health shakes were to be given three times per day.</p> <p>In an interview on 11-28-2012 at 1:32 PM, Unit Manager #1 indicted there should have been an intervention tried when Resident #71's eating had declined. UM #1 further indicated there was no intervention attempted she knew of.</p> <p>A care plan titled decreased nutrition dated 10-25-2012 included interventions of monitor food and fluid intake, offer encouragement to eat, offer snacks, and provide ordered diet and extra snacks.</p> <p>A review of Medication Administration Record (MAR) dated 10-2012</p>						

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	<p>indicated no supplements were started 10-2012.</p> <p>A review of the MAR dated 11-2012 indicated supplements (health shakes three times per day) were initiated 11-15-2012.</p> <p>In an interview on 11-28-2012 at 2:31 PM, the Food Services Supervisor indicated when notified of a weight loss, she observes the resident, discusses food preferences and discusses the loss with nursing, and recommends an intervention according to the discussion and her findings. Nursing would then notify the physician so the facility could send supplements consistently. The Food Services Supervisor then indicated she notified the dietician of weight losses on her visits at least every 2 weeks. She further indicated when she started noticing weight loss and decreased intake for Resident #71 on 10-18-2012, she thought it was because Resident #71 ate a lot of junk food at home and this is why she was losing weight on admission. She indicated she would then have talked to the dietician and nursing to get a plan together and start interventions. The Food Services Supervisor further indicated the facility had tried ice cream and other</p>			

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	<p>things for Resident #71, but it wasn't documented. She further indicated she had spoken with the Registered Dietician and had begun sending pudding for a snack, which should have been documented on the tray card. The Food Services Supervisor indicated the facility was trying to encourage Resident #71 to eat at the time of 10-15-2012 when decreased intakes were noted. She further indicated when residents are not eating supplements, the supplement becomes not feasible. The Food Services Supervisor additionally indicated the physician should have been notified and the shakes started on 10-26-2012.</p> <p>In an interview on 11-28-2012 at 2:46 PM, the dietician indicated Resident #71 had been reviewed on 10-26-2012. At that time she recommended health shakes twice daily. The dietician further indicated the healthshakes should have been started in the next day or two.</p> <p>3.1-5(a)(2)</p>			

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F0159 SS=A	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that</p>			

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	<p>receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on record review and interviews, the facility failed to notify Medicaid residents and/or their financial representatives timely of personal fund accounts amounts which were within \$200.00 of the Medicaid limits of personal assets.</p> <p>Finding includes:</p> <p>Review of the personal funds documentation for the facility, on 11/30/12 at 10:30 A.M., indicated for the month of November, there were two residents, who received Medicaid monies, whose personal fund accounts had surpassed the Medicaid limit of \$1500.00.</p> <p>Review of a letter, dated 11/20/12, from the Corporate Accounts Receivable staff, Employee #15, to the Admissions coordinator, Employee #16, indicated Resident #51 had \$1654.67 in her resident funds accounts, and Resident #107 had \$2832.26.</p>	F0159	<p>1. Corrective Action Resident #107 had been Medicaid, but recently went to Medicare A as the primary source of payment. Facilities are not allowed to collect a Medicaid liability while a resident is on Medicare A. Resident #51 gave \$600 to her son, and \$400 was donated to her church. Neither resident was over the resource limit on December 1 to jeopardize their eligibility for Medicaid.</p> <p>2. Other Residents identified The Admissions coordinator, Social Service Director and Accounts Receivable staff will monitor the resident's personal funds balance weekly, and will identify residents with a balance of \$1300 or more. The admission agreement for all residents state that the facility will notify the resident/responsible party if the resident fund balance reaches \$1300. (See Exhibit C) Documentation of the contacts will be made in the Business Office or Social Services notes.</p> <p>3. Systemic Changes The Admissions coordinator, Social Service Director and Accounts Receivable staff will identify residents who have a balance of</p>	11/30/2012	

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	<p>Interview, on 11/30/12 at 10:40 A.M., with the Admissions coordinator, Employee #16, indicated both residents had recently changed their payor source to Medicaid and their resident funds accounts had exceeded the limit on November 3, when they received their Social Security checks. She indicated she had not been informed of the issue until 11/20/12.</p> <p>Employee #16 indicated she had informed Resident #51's representative on 11/27/12 and arrangements were in the process for the resident to "gift" her family in order to reduce the amount of monies in her personal fund account below the allowable Medicaid limit.</p> <p>Employee #16 indicated she had informed Resident #107's representative on 11/26/12 of the issue with the personal fund account balance and arrangements were being made to inquire about spending some of the personal fund account monies on funeral arrangements. The documentation provided by Employee #16 indicated the facility was assisting the representative with the arrangements. Employee #16 indicated the arrangements, while still</p>		<p>\$1300 or more in their resident fund account. The resident and/or family will be notified of the need to spend down the balance so Medicaid will not be jeopardized.4. Monitor Corrective ActionThe Admissions coordinator, Social Service Director and Accounts Receivable staff will monitor the resident's personal funds balance weekly, and will identify residents with a balance of \$1300 or more. The Administrator will assist in monitoring compliance. Each resident is identified in the weekly A/R meeting to also assure compliance.ADDENDUM: The Acct. Receivable staff submits a weekly report of the most current resident fund account balances. The Social Service Director is notified of any balance over \$1300.00, and will notify the resident and/or family if monies need to be spent. The action taken will be documented in the ECS System. The SSD will complete a compliance report and present it monthly at the QA Committee. See Exhibit SS-1. The compliance goal is 100%, and if compliance is achieved in six (6) months, the study and report will be discontinued.</p>				

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	<p>in process, would be able to be made by December 1, which was the next day.</p> <p>Interview with the Administrator, on 11/30/12 at 11:55 P.M., indicated the facility had no written policy regarding notifying residents and/or representative regarding the personal fund account balances when they were nearing the Medicaid limit. She indicated it was the facility's "policy" to notify residents and/or their representatives when the personal fund accounts for Medicaid residents were within \$200.00 of the limit on the accounts.</p> <p>3.1-6(b)</p>			

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F0272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure 1 of 3 residents who met the criteria was accurately assessed for bladder incontinence and 1 of 3</p>	F0272	<p>1. Corrective Action Urinary Incontinence Resident #83 was discharged home. 2. Residents Identified The Nursing Unit Manager or designee will audit the plans of care for all residents,</p>	12/28/2012

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	<p>residents who met the criteria for activity review was accurately assessed for activity needs . (Resident #83)</p> <p>Finding includes:</p> <p>1. Resident #83 was observed on 11/28/12 and 11/29/12 in the therapy room working with therapists. The resident was noted to be in a wheelchair, was conversive, and could move her arms.</p> <p>Interview with Resident #83, on 11/29/12 at 8:45 A.M., indicated she was going to get to go home to live with her family on 11/30/12. The resident indicated she had had some issues with her bladder in the past but had it "under control now." She indicated she was able to transfer and toilet herself now.</p> <p>The clinical record for Resident #83 was reviewed on 11/28/12 at 1:30 P.M. Resident #83 had been admitted to the facility, initially on 06/28/12 with diagnoses, including but not limited to, MVA (motor vehicle accident) with blunt trauma to the head and seizures.</p> <p>The Admission MDS (Minimum Data Set) assessment, completed on</p>		<p>in order to identify a resident with need for a toileting plan to address urinary incontinence. For those residents with need for a toileting plan, the nursing manager or Restorative Nurse will initiate or update the plan of care to address urinary incontinence.</p> <p>3. Systemic Changes Upon admission, with a significant change in a resident's bladder function, and with each annual or significant change MDS assessment, the urinary continence will be assessed, including the use of "Bowel & Bladder Flow Sheet" (Exhibit D 1-2) which provides voiding pattern results. The nursing unit manager will include a summary of the voiding pattern results in the bladder assessment. Bladder assessments are also completed by the nursing unit manager with each resident's quarterly MDS assessment. The bladder assessment will become the basis for the care plan team initiating or updating these residents' individualized plan of care for urinary incontinence. Nursing staff inservices will be scheduled prior to Dec. 28, 2012.</p> <p>4. Monitoring the corrective action The Nursing Unit Manager will ensure that a bladder assessment is completed timely, and that a care plan is developed. The MDS Coordinator or designee will also monitor for compliance. The monthly QA Committee will be provided a</p>				

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	<p>07/10/12., indicated the resident's BIMS (Brief Interview of Mental Status) score was 12, and the resident required extensive staff assistance for transfer needs, locomotion needs, dressing, toileting, personal hygiene and bathing needs. The resident was also not walking. The resident was assessed to be not steady and required staff assist for moving from a seated position, for walking, turning around, moving on and off toilet, and surface to surface transfers. Impairment was noted on both upper and lower extremities on both sides. The resident was documented as always continent of her bowels and bladder.</p> <p>The initial bladder assessment for Resident #83, documented on 07/11/12 as a late entry for 06/28/12, indicated the resident stress incontinence but had complete control of her bladder.</p> <p>A "Bowel and Bladder Flow Sheet" form, documented for June 28 - 31, 2012 indicated of the 1 full and 3 partial days of documentation, the resident had 7 episodes of urinary incontinence. The CNA Flowsheet for Resident #83, for 06/28/12 - 07/01/12, indicated the resident demonstrated urinary incontinence on</p>		<p>summary report that identifies how many residents plans of care for urinary needs were initiated or updated. The Nursing Unit Manager is responsible to monitor and complete the summary report.1. Corrective Action ActivitiesResident #3 was an employee at this facility for a number of years and indeed is independent is the selection of activities he participates in. A comprehensive assessment was completed on 12/6/2012 (See Exhibit F 1-2).2. Residents IdentifiedThe Activity Director will audit resident's records to assure that complete, accurate and timely information is included. 3. Systemic ChangesUpon admission or with each annual or significant change MDS assessment, activity preferences will be documented and kept current.4. The Activity Director and MDS Coordinator will monitor for compliance. In addition, the Social Service/Activity Consultant will also monitor for compliance. The Activity Director will report compliance to the QA Committee monthly.ADDENDUM: F272, F315Monitoring will be completed by the Care Plan Coordinator - See Exhibit ASSESS -1. The QA Committee will review the outcomes monthly, and compliance will be expected at 100%, QA Committee review will be ongoing.</p>		

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	<p>3 of the 10 shifts documented.</p> <p>The Quarterly 11/19/12 , MDS assessment, indicated the resident had a BIM score of 15, transfer required limited staff assistance of 1, walking, dressing, personal hygiene, and toilet use required extensive staff assistance, wheelchair locomotion was independent. The resident required staff assistance for moving from a seated position, walking, turning around, moving on and off the toilet, and surface to surface transfers. The resident was assessed to have impairment to one side of her upper and lower extremities. The resident was assessed to be occasionally incontinent of her bladder and totally continent of bowel.</p> <p>Review of a bladder assessment, completed on 08/30/12 indicated the resident was having daily incontinence episodes, but had some control. The resident was also assessed to have stress incontinence and to have dribbling issues.</p> <p>A 14 day MDS assessment, completed on 09/06/12, indicated the resident was occasionally incontinent of both her bowel and bladder.</p>				

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	<p>Review of the bladder assessment, completed on 09/17/12, indicated the resident was having 2 - 6 days a week of incontinent episodes at night due to dribbling while coughing.</p> <p>A restorative care plan was initiated on 09/18/12 for toileting needs for Resident #83. Prior to 09/18/12, the only care plan regarding toileting needs indicated the resident needed assistance to toilet. There was no specific plan for addressing the toileting needs for Resident #83.</p> <p>Review of the bladder assessment, completed on 10/19/12, indicated the resident was only having one incontinent episode per week and was on a prompted voiding program. The type of incontinence was again stress incontinence dribbling while coughing.</p> <p>An interview, on 11/29/12 at 11:45 A.M., with MDS nurse #25, indicated she reviewed the unit manager's bladder assessments and restorative toileting documentation if the resident is on restorative to get the information she needs to document the MDS. She indicated, after reviewing the 4 day voiding patterning documentation and the CNA Flowsheet information for the assessment period for the</p>			

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	<p>initial MDS she should have documented the resident as a "1 (less than 7 episodes of incontinence) or even a 2 (7 or more episodes of urinary incontinence, but at least one episode of continent voiding" on the MDS section for incontinence. She also indicated she counted the number of shifts the resident was documented as incontinent on the restorative documentation and counted them as "episodes" but the documentation did not indicate the number of incontinent episodes the resident might have experienced in a shift.</p> <p>2. An interview with Resident #3, on 11/26/12 at 1:50 P.M., 2012 indicated he did not desire to attend facility activities because they did not interest him. During the interview with Resident #3 it was noted he had a clock/alarm and a radio on his side of the room but nothing else. The resident had a side chair facing the side of his dresser. The resident indicated he did not like television and occasionally his roommates television was left on and it bothered him.</p> <p>Resident #3 was observed at 10:39 A.M. on 11/28/12 in his room in a side chair leaned over asleep. He was again observed on 11/28/12 at 2:15</p>			

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	<p>P.M. in his room in a side chair leaned over asleep. There was a food committee meeting at 1:45 P.M. in the dining room but the resident was not in attendance.</p> <p>On 11/29/12 at 8:40 A.M., Resident #3 was not in his room or in the main dining room. On 11/29/12 10:30 A.M., Resident #3 was seated in a chair in his room. He indicated he had not gone to any of the facility activities but had received a shower earlier in the morning. Resident #3 was observed on 11/29/12 at 11:00 A.M., seated in his room in a side chair awake. He indicated he was aware they were painting in the garden room but says he did not wish to go to that activity. He indicated this morning he had received a shower and did not go to the 8:05 activity.</p> <p>On 11/29/12 at 2:00 P.M. and at 3:00 P.M., Resident #3 was noted to be seated in his room in a side chair facing the side of his dresser awake.</p> <p>The health care plan for Resident #3, indicated the goal was for the resident to be in two activities a week.</p> <p>An interview with the Activity Director, Employee #11, on 11/30/12 9:40 A.M., indicated the resident preferred</p>			

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	<p>individual self initiated activities such as walking around the facility and reading the newspaper. She indicated the resident went to over 100 activities per month. The Activity Director looked clear back through 1989 and could not find any complete activity assessment for Resident #3. The Activity Director said he (Resident #3) was doing so much better at coming to activities lately. The Activity Director indicated she was counting walking as an activity, reading the newspaper as an activity because the resident gets a newspaper, she was also counting the noon "snack and yak" as an activity because it provided a time for socialization but no activity staff were monitoring the resident's during snack and yak to ensure he was actually sitting and conversing with other residents and there was usually no staff provided activity during the daily noon "Snack and Yak" but the substantial food snack was served.</p> <p>An interview with Activity Director, on 11/30/12 at 10:12 A.M. indicated she could not locate an activity assessment for Resident #3. She did provide a partial activity assessment, completed in 10/17/2009, which indicated the resident expressed interests in church clubs, animals,</p>						

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	<p>birdwatching, indoor/outdoor walks, movies, and television/radio. Another Activity Preferences Interview form, completed on 12/09/10, indicated the resident responded it was somewhat important to have books, newspapers, and magazines to read. He answered "not very important" when asked how important it was for him to listen to music, be around animals such as pets, keep up with the news, do things with groups of people, do your favorite activities, go outside and get fresh air, and participate in religious services or practices. She indicated the resident had been here for a long time and she had been trained if there were no changes in the resident's activity interests they did not have to do a new activity assessment. It was unclear when or why the resident's preferences had changed from the 2009 partial assessment to the 2010 activity preferences interview, but there was no way to assure the activity plan for Resident #3 was individualized because there was no current thorough activity assessment.</p> <p>3.1-31(a)</p>			

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F0279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interviews, the facility failed to: A: initiate a care plan timely for 1 of 14 residents whose charts were reviewed for careplans (Resident #83); B: initiate care plans regarding hypnotic use for 2 of 10 residents reviewed with psychotropic medication. (Resident #89, and Resident #117)</p> <p>Finding includes: A. Resident #83 was observed on</p>	F0279	A. 1. Corrective Action Resident #83 was discharged home. 2. Residents Identified The Nursing Unit Manager or designee will audit the plans of care for all residents, in order to identify a resident with need for a toileting plan to address urinary incontinence. For those residents with need for a toileting plan, the nursing manager or Restorative Nurse will initiate or update the plan of care to address urinary incontinence. 3. Systemic Changes Upon admission, with a significant change in a resident's bladder function, and with each annual or significant change MDS	12/28/2012			

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	<p>11/28/12 and 11/29/12 in the therapy room working with therapists. The resident was noted to be in a wheelchair, was conversive, and could move her arms.</p> <p>Interview with Resident #83, on 11/29/12 at 8:45 A.M., indicated she was going to get to go home to live with her family on 11/30/12. The resident indicated she had had some issues with her bladder in the past but had it "under control now." She indicated she was able to transfer and toilet herself now.</p> <p>The clinical record for Resident #83 was reviewed on 11/28/12 at 1:30 P.M. Resident #83 had been admitted to the facility, initially on 06/28/12 with diagnoses, including but not limited to, MVA (motor vehicle accident) with blunt trauma to the head and seizures.</p> <p>The Admission MDS (Minimum Data Set) assessment, completed on 07/10/12., indicated the resident's BIMS (Brief Interview of Mental Status) score was 12, and the resident required extensive staff assistance for transfer needs, locomotion needs, dressing, toileting, personal hygiene and bathing needs. The resident was also not walking.</p>		<p>assessment, the urinary continence will be assessed, including the use of "Bowel & Bladder Flow Sheet" (Exhibit D 1-2)which provides voiding pattern results. The nursing unit manager will include a summary of the voiding pattern results in the bladder assessment. Bladder assessments are also completed by the nursing unit manager with each resident's quarterly MDS assessment. The bladder assessment will become the basis for the care plan team initiating or updating these residents' individualized plan of care for urinary incontinence. Nursing staff inservices will be scheduled prior to 12/28/2012.4. Monitoring the corrective actionThe Nursing Unit Manager will ensure that a bladder assessment is completed timely, and that a care plan is developed. The MDS Coordinator or designee will also monitor for compliance. The monthly QA Committee will be provided a summary report that identifies how many residents plans of care for urinary needs were initiated or updated. The Nursing Unit Manager is responsible to monitor and complete the summary report.B. 1. Corrective Action A care plan was written for resident #89 addressing insomnia. The care plan was shared with the surveyor on 11/29/2012. (See Exhibit E 1-2) 2. Residents Identified Every</p>		

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	<p>The resident was assessed to be not steady and required staff assist for moving from a seated position, for walking, turning around, moving on and off toilet, and surface to surface transfers. Impairment was noted on both upper and lower extremities on both sides. The resident was documented as always continent of her bowels and bladder.</p> <p>The initial bladder assessment for Resident #83, documented on 07/11/12 as a late entry for 06/28/12, indicated the resident stress incontinence but had complete control of her bladder.</p> <p>A "Bowel and Bladder Flow Sheet" form, documented for June 28 - 31, 2012 indicated of the 1 full and 3 partial days of documentation, the resident had 7 episodes of urinary incontinence. The CNA Flowsheet for Resident #83, for 06/28/12 - 07/01/12, indicated the resident demonstrated urinary incontinence on 3 of the 10 shifts documented.</p> <p>The Quarterly 11/19/12 , MDS assessment, indicated the resident had a BIM score of 15, transfer required limited staff assistance of 1, walking, dressing, personal hygiene, and toilet use required</p>		<p>resident receiving a hypnotic or has a diagnosis of insomnia was reviewed and has a care plan in place. 3. Systemic Changes A care plan will be developed for every resident admitted with a diagnosis of insomnia and/or receiving a hypnotic. In addition, any resident with a new diagnosis of insomnia or has a new order for a hypnotic, a care plan will be developed. Nursing staff inservices will be scheduled prior to 12/28/2012. 4. Corrective Action Monitoring The Care Plan Team will review to assure each insomnia care plan is in place at each care plan meeting. The Social Service Consultant will also monitor for compliance.ADDENDUM: F279:Refer to the Bowel & Bladder Flow Sheet - Exhibit D1 & D2 The Unit Nurse Manager is responsible to assure the Flow Sheets are completed correctly.Resident #117 was discharged home. The QA Committee will monitor monthly and will be ongoing. A compliance rate of 100% will be expected. Refer to Exhibit Access - 1 and Exhibit Access - 2.</p>				

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	<p>extensive staff assistance, wheelchair locomotion was independent. The resident required staff assistance for moving from a seated position, walking, turning around, moving on and off the toilet, and surface to surface transfers. The resident was assessed to have impairment to one side of her upper and lower extremities. The resident was assessed to be occasionally incontinent of her bladder and totally continent of bowel.</p> <p>Review of a bladder assessment, completed on 08/30/12 indicated the resident was having daily incontinence episodes, but had some control. The resident was also assessed to have stress incontinence and to have dribbling issues.</p> <p>A 14 day MDS assessment, completed on 09/06/12, indicated the resident was occasionally incontinent of both her bowel and bladder.</p> <p>Review of bladder assessment, completed on 09/17/12, indicated the resident was having 2 - 6 days a week of incontinent episodes at night due to dribbling while coughing.</p> <p>A restorative care plan was initiated on 09/18/12 for toileting needs for</p>			

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	<p>Resident #83. Prior to 09/18/12, the only care plan regarding toileting needs was an ADL and strengthening care plan, initiated on 06/28/12, which indicated the resident needed assistance to toilet and transfer. There was no specific plan for addressing the toileting needs for Resident #83.</p> <p>Review of the bladder assessment, completed on 10/19/12, indicated the resident was only having one incontinent episode per week and was on a prompted voiding program. The type of incontinence was again stress incontinence dribbling while coughing.</p> <p>B. 1. Resident #89's record was reviewed on 11-29-2012 at 1:29 PM. Resident #89's diagnoses included but were not limited to, diabetes, high cholesterol, anemia, peripheral neuralgia, blind, heart failure, peripheral vascular disease, asthma, lung disease, GERD, osteoarthritis, dysphagia, and insomnia.</p> <p>A current physician's order summary dated 11-2012 indicated Resident #89 was ordered Ambien (a hypnotic) 5 milligrams (mg) every day for insomnia.</p>				

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	<p>A care plan titled hopelessness dated 12-16-2011 included interventions of observe for signs increasing depression, decreased socialization and comments, monitor side effects of medications, administer medications, encourage to express feelings, reassure resident staff cares about her, involve in conversations about family life and reminiscing, offer choices and allow to make decisions, provide supportive visits, referral as needed to psych services, and involve in activities. The care plan did not indicated sleeplessness or insomnia was a concern with Resident #89. There was no care plan addressing insomnia.</p> <p>In an Interview on 11-29-2012 at 2:49 PM, SSD #2 indicated a care plan should have been initiated.</p> <p>B. 2. Resident #117's record was reviewed 11-29-2012 at 2:25 PM. Resident #117's diagnoses included but were not limited to: depression, pain, high blood pressure, GERD, kidney disease, lumbago, and sleep disturbance.</p> <p>A current physician's order summary dated 11-2012 indicated Ambien 10 mg every day was to be given as</p>			

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	<p>needed starting 11-10-2012.</p> <p>the Medication Administration Record dated 11-2012 indicated Ambien 10 mg had been given almost every day. The Ambien had been given every day 11-10 through 11-18, then 11-20 thru 11-27-2012.</p> <p>A care plan titled hopelessness included interventions of observe for sadness and sad facial expressions, administer med's, talk about family, reminisce, encourage decision making, encourage activity participation, provide supportive visits, refer to psych as needed. The care plan did not indicated sleeplessness or insomnia was a concern with Resident #117. There was no care plan addressing insomnia.</p> <p>In an interview on 11-29-2012 at 2:49 PM, SSD #2 indicated a care plan should have been initiated.</p> <p>3.1-35(a)</p>				

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F0280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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 the care plan with interventions for a significant weight loss for 1 of 3 residents reviewed for care plan updates. (Resident #71)</p> <p>Findings include:</p> <p>Resident #71's record was reviewed 11-28-2012 at 10:39 AM. resident #71's diagnoses included but were not limited to: malignant colon cancer, high cholesterol, gout, anemia, dementia, depression, heart disease, pulmonary hypertension, congestive heart failure, Barrett's esophagus,</p>	F0280	<p>1. Corrective ActionThe physician was notified on 11/15/2012 and an order for a supplement was received for resident #71. In addition, the Nursing Unit Manager will review for significant weight changes, and will ensure the physician is notified promptly.2. Other Residents having a Potential concernThe Dietitian along with the Nursing Unit Manager will review resident weights and all RD recommendations will be followed to include physician notification. All RD recommendations will be discussed and documentation of interventions will be made. The RD visits weekly and will follow up</p>	12/28/2012	

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	<p>osteoarthritis, and adult failure to thrive.</p> <p>Resident #71's weight on 9-21-2012 was 141; on 10-18-2012, her weight was 138, a 2.1% weight loss; on 11-1-2012, her weight was 129, an 8.5% weight loss.</p> <p>A dietary assessment dated 9-25-2012 indicated swallowing was a concern, but no interventions were noted to address possible weight concern related to diagnoses of cancer and anemia. Adult failure to thrive was not added as a diagnosis at that time.</p> <p>A nutritional assessment dated 9-25-2012 indicated intakes were 75-100% of meals. The assessment further indicated refusal to wear dentures, and diagnosis of cancer and swallowing difficulty. The assessment indicated Resident #71 was at moderate risk for loss. Resident #71's needs and preferences were reviewed. The recommendation was the facility was to send soft foods for her to eat as an intervention.</p> <p>Resident #71's intake declined between 10-3-2012 and 10-15-2012 according to the nutritional</p>		<p>from the previous week's notes with the Nursing Unit Manager or designee.3. Systemic ChangesThe RD visit notes will be discussed with the Nursing Unit Manager, who will follow up with physician notification. The Dietary Manager is also responsible to monitor compliance.4. Monitor of Corrective ActionThe Dietary Manager will present the RD recommendations to the Nursing Unit Manager, who will report compliance to the QA Committee monthly. This goal has been added to the QA Committee function (Refer to Exhibit B 1-2) The goal was presented to the QA Committee at its 12/12/2012 meeting. ADDENDUM: F 280The physician was notified on 11/15/2012 and an order for a supplement was received for resident #71. In addition, the Nursing Unit Manager will review for significant weight changes, and will ensure the physician is notified promptly. All residents have been reviewed for significant weight loss or gain. See Exhibit RD - 1. The MD & RD will be notified as needed.Interventions have been implemented and care plans have been updated. The QA Committee will monitor monthly and ongoing with an expected compliance rate of 100%,</p>				

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	<p>assessment dated 10-15-2012. The assessment indicated intakes dipped to 25-75% and Resident #71's weight began to decline 10-15-2012. There is no note the dietician was notified and no note the physician was notified.</p> <p>A nutritional assessment dated 11-15-2012, indicated Resident #71's weight had declined to 128. There was still no note of dietician or physician notification.</p> <p>Dietary notes dated 10-26-2012 indicated weight decline and intakes decline to about 50%, but noted Resident #71's appetite had increased in recent days. The notes indicated intervention was to send health shakes.</p> <p>In an interview on 11-28-2012, the Minimum Data Set assessment coordinator indicated Resident #71 had edema, so some weight loss was expected and no MD or family notification was noted in the record regarding weight loss.</p> <p>According to a physician's order summary dated 11-2012, health shakes were not added until 11-15-2012. A review of discontinued physician's orders indicated no other</p>			

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	<p>supplement had been ordered prior to the 11-15-2012 order. The 11-15-2012 order indicated the health shakes were to be given three times per day.</p> <p>In an interview on 11-28-2012 at 1:32 PM Unit Manager (UM) #1 indicated there should have been an intervention tried when Resident #71's eating had declined. UM #1 further indicated there was no intervention attempted she knew of.</p> <p>A care plan titled decreased nutrition dated 10-25-2012 included interventions of monitor food and fluid intake, offer encouragement to eat, offer snacks, and provide ordered diet and extra snacks. The care plan did not include the risk for weight loss, the supplements attempted, or health shakes given three times per day.</p> <p>In an interview on 11-28-2012 at 2:31 PM, the Food Services Supervisor indicated the care plan should have been updated when the weight loss occurred and when the health shakes were started.</p> <p>3.1-35(d)(2)(B)</p>				

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F0315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure 1 of 3 residents who met the criteria was accurately assessed for bladder incontinence needs and toileting needs and promptly placed on a toileting plan to improve her bladder continency status. (Resident #83)</p> <p>Finding includes:</p> <p>1. Resident #83 was observed on 11/28/12 and 11/29/12 in the therapy room working with therapists. The resident was noted to be in a wheelchair, was conversive, and could move her arms.</p> <p>Interview with Resident #83, on 11/29/12 at 8:45 A.M., indicated she was going to get to go home to live with her family on 11/30/12. The</p>	F0315	<p>1. Corrective Action Resident #83 was discharged to home. 2. Identification of others Potentially Affected The Nursing Unit Manager or designee will audit the plans of care for all residents, in order to identify a resident with need for a toileting plan to address urinary incontinence. For those residents with need for a toileting plan, the nursing manager or Restorative Nurse will initiate or update the plan of care to address urinary incontinence. 3. Systemic Changes Upon admission, with a significant change in a resident's bladder function, and with each annual or significant change MDS assessment, the urinary continence will be assessed, including the use of "Bowel & Bladder Flow Sheet" (Exhibit D 1-2) which provides voiding pattern results. The nursing unit manager will include a summary of the voiding pattern results in the bladder assessment. Bladder</p>	12/28/2012			

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	<p>resident indicated she had had some issues with her bladder in the past but had it "under control now." She indicated she was able to transfer and toilet herself now.</p> <p>The clinical record for Resident #83 was reviewed on 11/28/12 at 1:30 P.M. Resident #83 had been admitted to the facility, initially on 06/28/12 with diagnoses, including but not limited to, MVA (motor vehicle accident) with blunt trauma to the head and seizures.</p> <p>The Admission MDS (Minimum Data Set) assessment, completed on 07/10/12., indicated the resident's BIMS (brief interview for mental status) score was 12, and the resident required extensive staff assistance for transfer needs, locomotion needs, dressing, toileting, personal hygiene and bathing needs. The resident was also not walking. The resident was assessed to be not steady and required staff assist for moving from a seated position, for walking, turning around, moving on and off toilet, and surface to surface transfers .Impairment was noted on both upper and lower extremities on both sides. The resident was documented as always continent of her bowels and bladder.</p>		<p>assessments are also completed by the nursing unit manager with each resident's quarterly MDS assessment. The bladder assessment will become the basis for the care plan team initiating or updating these residents' individualized plan of care for urinary incontinence.4. Monitoring the corrective actionThe Nursing Unit Manager will ensure that a bladder assessment is completed timely, and that a care plan is developed. The MDS Coordinator or designee will also monitor for compliance. The monthly QA Committee will be provided a summary report that identifies how many residents plans of care for urinary needs were initiated or updated. The Nursing Unit Manager is responsible to monitor and complete the summary report.ADDENDUM: F272, F315Monitoring will be completed by the Care Plan Coordinator - See Exhibit ASSESS -1. The QA Committee will review the outcomes monthly, and compliance will be expected at 100%, QA Committee review will be ongoing.</p>		

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	<p>The initial bladder assessment for Resident #83, documented on 07/11/12 as a late entry for 06/28/12, indicated the resident had stress incontinence but had complete control of her bladder.</p> <p>A "Bowel and Bladder Flow Sheet" form, documented for June 28 - 31, 2012 indicated of the 1 full and 3 partial days of documentation, the resident had 7 episodes of urinary incontinence. The CNA Flowsheet for Resident #83, for 06/28/12 - 07/01/12, indicated the resident demonstrated urinary incontinence on 3 of the 10 shifts documented.</p> <p>The Quarterly 11/19/12 , MDS assessment, indicated the resident had a BIM score of 15, transfer required limited staff assistance of 1, walking, dressing, personal hygiene, and toilet use required extensive staff assistance, wheelchair locomotion was independent. The resident required staff assistance for moving from a seated position, walking, turning around, moving on and off the toilet, and surface to surface transfers. The resident was assessed to have impairment to one side of her upper and lower extremities. The resident was</p>						

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	<p>assessed to be occasionally incontinent of her bladder and totally continent of bowel.</p> <p>Review of a bladder assessment, completed on 08/30/12 indicated the resident was having daily incontinence episodes, but had some control. The resident was also assessed to have stress incontinence and to have dribbling issues.</p> <p>A 14 day MDS assessment, completed on 09/06/12, indicated the resident was occasionally incontinent of both her bowel and bladder.</p> <p>Review of bladder assessment, completed on 09/17/12, indicated the resident was having 2 - 6 days a week of incontinent episodes at night due to dribbling while coughing.</p> <p>A restorative care plan was initiated on 09/18/12 for toileting needs for Resident #83. Prior to 09/18/12, the only care plan regarding toileting needs indicated the resident needed assistance to toilet. There was no specific plan for addressing the toileting needs for Resident #83.</p> <p>Review of the bladder assessment, completed on 10/19/12, indicated the resident was only having one</p>						

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	<p>incontinent episode per week and was on a prompted voiding program. The type of incontinence was again stress incontinence dribbling while coughing.</p> <p>An interview, on 11/29/12 at 11:45 A.M., with MDS nurse #25, indicated she reviewed the unit manager's bladder assessments and restorative toileting documentation if the resident is on restorative to get the information she needs to document the MDS. She indicated, after reviewing the 4 day voiding patterning documentation and the CNA Flowsheet information for the assessment period for the initial MDS she should have documented the resident as a "1 (less than 7 episodes of incontinence) or even a 2 (7 or more episodes of urinary incontinence, but at least one episode of continent voiding" on the MDS section for incontinence. She also indicated she counted the number of shifts the resident was documented as incontinent on the restorative documentation and counted them as "episodes" but the documentation did not indicate the number of incontinent episodes the resident might have experienced in a shift.</p> <p>3.1-41(a)(2)</p>				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155710	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/30/2012
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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interviews, the facility failed to ensure the resident environment was free from unsecured chemicals and potentially dangerous personal hygiene items on 2 of 3 resident units.</p> <p>Finding includes:</p> <p>During the Environmental tour of the facility, conducted on 11/30/12 from 1:00 P.M. - 2:10 P.M., the following was noted: On the access hallway from the main hub of the facility to the 100 unit, a housekeeping closet was noted to be unlocked. The closet contained gallon containers of disinfectant and other cleaning chemicals as well as spray bottles and quart sized containers of toilet cleaner.</p> <p>Interview with the Administrator, during the tour, on 11/30/12 at 1:05 P.M., indicated the closet should have been locked and the facility did have some confused, ambulatory residents who wandered. The Administrator</p>	F0323	<p>1. Corrective ActionThe housekeeping door lock in the front hall was immediately changed during survey with a self locking mechanism, so the door will not be unlocked at any time. This will be a permanent change not to allow confused residents access to the closet at any time. Personal care items in room #215 was secured not to allow confused residents access.2. Potential ResidentThe Housekeeping manager and staff will monitor resident rooms and personal care items will be placed in a Rubbermaid container with lid, and the container will be kept in the bedside dresser. Residents and families will be notified of this protocol upon admission. This will be discussed at the Resident Council and Family meetings.3. Systemic changesHousekeeping and maintenance staff will monitor the housekeeping door and resident rooms daily to assure the safety of all residents.4. The Maintenance and Housekeeping supervisors will report compliance checks to the QA Committee monthly to assure continued safety. Any identified issues will</p>	12/28/2012

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	<p>indicated there were "not as many wandering , confused residents" as there had been.</p> <p>In Resident room #215, occupied by Residents # 26 and 19, there was a gallon sized container of hand sanitizer, a full bottle of mouthwash, a container of medicated powder, full bottles of perfume, and other bottles of personal hygiene items noted to be out on open shelves and overbed tables. An interview with Residents # 26 and 19 indicated they had issues occasionally with confused residents wandering into their room and "taking" and/or "rearranging" their personal items.</p> <p>3.1-45(a)(1)</p>		<p>be addressed and corrected immediately. The Administrator will also check locks and resident rooms for compliance.</p>		

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F0356 SS=A	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p>	F0356	<p>1. Corrective ActionThe posted nursing staffing information is now posted at the front entrance hall at wheelchair height. 2. Affected residentsThe posted nursing staffing information location will be shared with</p>	11/30/2012			

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	<p>Based on observation and interview the facility failed to post nursing staffing in an area that was easily accessible for the residents to read. this had the potential to affect 32 wheelchair bound residents in the facility.</p> <p>Findings include:</p> <p>During a the initial tour of the facility on 11-26-2012 at 10:32 AM, nursing staffing was observed to be posted in a window in the front office window.</p>		<p>residents, including the resident council. 3. Systemic changesThe location of the nursing staffing information is posted at the front entrance hall at wheelchair height, and this location will be permanent.4. The HR Director, which is responsible for the nursing staffing information, will assure that the report is posted daily. The facility Administrator will also monitor for compliance and will address inconsistencies with the HR Director.ADDENDUM: F356The HR Director will complete an audit to assure compliance of the nursing staffing information. A report summary will be presented to the QA Committee monthly for 6 months, with a goal of 100% compliance. When compliance is achieved, the QA Committee will no longer monitor. See Exhibit HR - 1.</p>		

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	<p>The window height is a little shorter than shoulder high.</p> <p>In an interview with Resident # on 11-29-2012 at 9:12 AM, he indicated he could not read the staffing posted in the administration window because it was too high to see.</p> <p>3.1-13-(a)</p>			

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F0364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview the facility failed to ensure food was served at a palatable temperature for 1 resident (#19) of 18 residents reviewed for food palatability.</p> <p>Findings include:</p> <p>On 11/26/12, at 12:35 P.M., an interview with resident #19 indicated food was often ice cold when served to her. The resident indicated she ate in her bedroom for meals and breakfast especially was not served at the proper temperature.</p> <p>On 11/28/12 at 10:42 A.M., a second interview was conducted with resident #19 who re-interated her food is often cold when served to her, especially at breakfast.</p> <p>An observation on 11/30/12 at 9:00 A.M. indicated the test tray at the point of delivery for resident #19, the eggs were 96 degrees at point of service after removal from the food cart.</p>	F0364	<p>1. Corrective ActionThe temperatures of food served is monitored daily by the Dietary Manager. The facility plans to purchase a Thermal Pellet system, which will maintain proper serving temperatures of the food served for up to two (2) hours. 2. Identify Potential AffectThe meals served on the resident units will be within acceptable ranges for all meals. The Thermal Pellet system will be utilized per factory directives by all dietary staff.3. Systemic ChangesResidents served on the resident units will be provided with food at appropriate temperatures (120 - 160 degrees) with the thermal system.4. MonitoringThe Dietary Manager will be responsible to monitor food temperatures, along with the Registered Dietitian, who will check food temperatures on her weekly visits. A report of food temperature variances will be presented to the QA Committee monthly. Individual resident interviews will continue to be completed to assure satisfaction.ADDENDUM: F364Bids have been obtained, and wiring for the new pellet</p>	12/30/2012			

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	3.1-21(a)(1)		system has been completed. We anticipate an installation date no later than 1/31/2013.		