

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155666	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/29/2012
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NAME OF PROVIDER OR SUPPLIER WESLEY HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1751 WESLEY ROAD AUBURN, IN 46706
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 21, 22, 23, 24, 25, and 29, 2012</p> <p>Facility number: 000307 Provider number: 155666 AIM number: 100285660</p> <p>Survey team: Diane Nilson, RN, TC Rick Blain, RN - May 21, 22, 24, 25, and 29, 2012 Sue Brooker, RD - May 21, 22, 23, 24, 2012 Angela Strass, RN - May 21,22, 23, 24, and 25, 2012</p> <p>Census bed type: SNF/NF:50 Total: 50</p> <p>Census payor type: Medicare: 7 Medicaid: 38 Other: 5 Total: 50</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>This plan of correction is prepared and executed because the provisions of the state and federal law require it. This plan of correction shall not be deemed an admission to, or agreement with the survey allegations. Wesley Healthcare Center maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render the residents, nor are they of such character so as to limit our capability to render adequate care. Wesley Healthcare Center further maintains that the allegations set forth herein do not substantiate or constitute substandard quality of care. Please accept the last date noted on the plan of correction as the facility's credible allegation of compliance Wesley Healthcare Center requests paper compliance for F244, F279, F282, F318 and F322.</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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	Quality review completed 6/4/12 by Jennie Bartelt, RN.				

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F0244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>Based on record review and interview, the facility failed to ensure resolution of grievances voiced during 7 of 12 resident council meetings regarding timely response to call lights.</p> <p>Finding Includes:</p> <p>On 5/25/12 at 1:15 p.m., interview with the Resident Council President indicated he had been the Council President for 3 months, and every month residents complain about call lights not being answered timely. The Resident Council President indicated he waited 30 minutes this morning to get his call light answered, and waited another 30 minutes with his light on to get off of the bedpan. Further discussion indicated he felt evenings and weekends were the worst.</p> <p>On 5/25/12 at 1:30 p.m.m review of Resident Council Minutes indicated residents had complained about call lights in July 2011, September 2011,</p>	F0244	F244 I. It is the policy of Wesley Healthcare that grievances and recommendations noted will be brought to the attention of Social Services, Interdisciplinary Team and Administration. Residents may express complaints, resolve disputes or bring attention to incidents, conditions, practices and or policies of Wesley Healthcare that may violate resident rights at any time. Social Services, the Interdisciplinary Team and Administration will respond to said grievances and recommendations. Social Services will follow up with residents expressing grievance/recommendations within 1 week after said grievance/recommendations were addressed by Interdisciplinary Team involved. If resident grievance/ recommendation remains without change, appropriate Interdisciplinary Team and Administration will be notified to make additional changes until grievance/recommendation is solved. No resident shall be punished or retaliated against for expressing a grievance or	06/15/2012	

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	<p>October 2011, January 2012, March, 2012, April 2012 and May 2012. Although the facility had made a written response to the complaints, the residents still had concerns during the above listed months, as follows:</p> <p>July 2011- Residents complained of call lights not being answered in a timely manner. The facility response was "Staff educated on the importance of answering call lights in a timely manner."</p> <p>September 2011-Residents complained of call light response being very slow. The facility response was "Aids [sic] and nurses educated on the importance of answering call lights in a timely manner."</p> <p>October 2011-Residents complained of call light response being very slow. The facility response was "Aids [sic] and nurses educated on the importance of answering call lights in a timely manner."</p> <p>January 2012-Residents complained about call lights, stating "sometimes the girls do good, other days it takes forever." The facility response was "Director of Nursing and the Assistent Director of Nursing spoke with all staff about answering call lights. If nursing</p>		<p>recommendation. This policy was updated 6/11/2012 to include aforementioned.II. On 6/11/2012 the President of the Resident Council agreed to having additional staff, namely, DON or designee to attend all or portion of Resident Council Meeting ongoing as residents and staff deem appropriate to increase communication between residents and staff and to ensure all grievances/ recommendations are understood and noted. CNA hours were changed from 5-530 to 4-430 to aide in availability to answer call lights. A new position from 9A-930PM was added to day shift to also assist in the efficiency of call light response time. III. Social Services, Interdisciplinary Team, and Administration were educated on updated policy and procedure on 6/11/2012.IV. DON or designee will monitor for effective changes with grievances and recommendations biweekly for first month and once a month thereafter for 5 months. If the grievances/ recommendations are found to be without change, the DON or designee will find party responsible and in-service individual, if applicable, or begin progressive discipline. ADON or designee will monitor for call light response time daily for 3 months and weekly thereafter to monitor call light response time and address specific problems or complaints. V. Date of</p>		

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	<p>staff was needed for task then whoever answered the light went and told a CNA or a nurse."</p> <p>March 2012-Residents complained about call lights and nurses not answering call lights. The facility response was "only one CNA per hall allowed to take lunch break at a time. Nurses were reminded to answer call lights. Nurses informed about being more efficient about meeting the residents needs."</p> <p>April 2012-Residents complained it takes over 45 minutes for call lights to be answered, residents being left on the bed pan too long. The residents also complained that 80% of nurses will not answer the call lights." The facility response was "CNA's re-educated and given 1 week time frame to improve call light times. Nurses and Respiratory Therapists reminded they must answer call lights."</p> <p>May 2012-Residents complained about call lights. They indicated nurses state it is not their job to answer call lights. The facility response was "Director of Nursing and the Assistant Director of Nursing will be addressing staff about the importance of time management and</p>		Completion 6/15/2012.		

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	<p>team work."</p> <p>On 5/25/12 at 1:45 p.m., interview with the Director of Nursing indicated she has told the CNA'S (Certified Nursing Assistants) they need to answer the call lights as soon as possible.</p> <p>On 5/24/12 at 1:50 p.m. review of the facility Policy for "Call Lights" dated 10/5/09 indicated the following:</p> <ol style="list-style-type: none"> 1. Respond to call lights promptly. 2. All staff are required to answer call lights, if they cannot meet the need of the resident they must leave the light on and find a staff member who can meet the residents need. <p>3.1-3(l)</p>				

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F0279 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 observation, interview, and record review, the facility failed to develop an activity care plan which included measurable goals, for 1 of 3 residents reviewed for activities, Resident #31, in a sample of 8 residents who met the criteria for activities.</p> <p>Findings include:</p> <p>Resident #31 was not observed out of her room at any time on 5/21/12 or 5/22/12.</p>	F0279	F279I. It is the policy of Wesley Healthcare that all care plans are to include: date of initiation, problem, goal with measurable time frame, interventions with responsible discipline, resident identifiers such as; name, physician, room number and medical record number. This was updated 4/18/2011.II. Activities Department was in-serviced by activities consultant 6/04/2012 and 6/08/2012 by DON and MDS coordinator on proper care plan documentation and assessment. Activities department was given a care plan tool for planning activities with measurable goals	06/15/2012	

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	<p>The Activity Director was interviewed at 11:57 a.m. on 5/23/12, regarding Resident #31. She indicated the resident was on a ventilator and was very self-conscious about being around people. The Activity Director indicated the resident preferred to stay in her room and 1:1 activities were provided for the resident at least 5 days a week by the Activity Director. She indicated the resident enjoyed Bible readings.</p> <p>The resident record was reviewed at 1:30 p.m. on 5/24/12.</p> <p>The activity progress note, dated 3/21/12, indicated the resident accepted visits from the clown, dogs, cafe, ice cream social, and preferred to do independent activities.</p> <p>Review of the activities attendance record provided by the Activity Director at 9:20 a.m. on 5/25/12, for April and May 2012 indicated the resident was involved in an activity daily to twice daily at least 5 times a week.</p> <p>The Activity Director was interviewed at 9:20 a.m. on 5/25/12, and indicated Monday through Friday, on a daily basis, she went to the resident's room and read to the resident from the</p>				<p>by activities consultant to aide in future care planning.III. All residents have new care plans developed for activities with measurable goals.IV. The Activities Consultant or designee will audit the activities care plans every month for 6 months. The results of the audit will be shared with the activities director and consultant for alterations if necessary.V. Date of Completion is 6/15/2012.</p>		

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	<p>morning devotional. She indicated the other activities listed were room visits, such as "twilight the clown," as the resident preferred to stay in her room.</p> <p>The activity care plan was reviewed at 9:35 a.m. on 5/25/12. Only 2 problem areas were listed on the care plan. The first problem area was dated 6/8/09, and indicated the resident was a long term placement, was on oxygen and in a wheelchair. The care problem indicated the resident was alert and cheerful and had an interest in crafts, music, church, and reading her Bible. An additional note indicated the resident might benefit from 1:1 visits for additional stimulation; however, this was discontinued in October, 2009.</p> <p>A goal for this problem indicated the resident would attend activities of choice such as crafts, music, and church events. Also, the resident would pursue her own independent activities such as watching TV and reading her Bible through the next review. A goal, which was discontinued in October 2009, indicated the resident would accept 1:1 visits for additional stimulation.</p> <p>The only other problem area listed on the activity careplan was documented</p>				

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	<p>on 8/24/11 and indicated the resident preferred in room activities or 1:1 visits when not feeling well. There was no goal written for this problem area. The careplan indicated the care plans were reviewed on August, 2011, November, 2011, and March, 2012.</p> <p>The Activity Director was interviewed at 9:20 a.m. on 5/25/12, and indicated she did not write a goal for the resident, because the resident did not feel well, so she didn't have a goal at this time. The Activity Director indicated the previous activity director had left the facility in 2010 and had discontinued the 1:1 visits for the resident in October 2009. The Activity Director indicated she began employment with the facility in November 2010. She indicated at that time the resident was coming out of her room for activities. She indicated the resident was hospitalized, and before she went to the hospital was on a trach mask, but when she returned the resident was on a ventilator, so did not want to come out of her room. The Activity Director indicated she wrote the new careplan problem for 1:1 visits on 8/24/11 when the resident was not feeling well, but did not write a goal for the problem.</p>						

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	<p>The Director of Nursing Services was interviewed at 10:20 a.m. on 5/25/12, and indicated there should be goals written for activities and other problem areas, and new care plans should have been written between 6/8/09 and 8/24/11.</p> <p>3.1-35(a)</p>			
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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician orders were followed for 1 resident, (Resident #61), in a sample of 10 residents reviewed for medications.</p> <p>Findings include:</p> <p>1. Review of the record for Resident #61 at 11:00 a.m. on 5/23/12, indicated a physician's order, dated 5/8/12, for artificial tears, 1 drop in both eyes, four times a day, for 2 weeks.</p> <p>Review of the Medication Administration Record (MAR) for Resident #61 indicated artificial tears were to be given to the resident 4 times a day, 1 drop in both eyes, for 2 weeks. The drops were initialed as given on 5/10 and 5/11/12, and on 5/12/12, LOA (leave of absence) was documented in the time frames. Between 5/13 and 5/23/12, the initials in the time frames for the medications were circled, and "stop" was documented after 5/23/12. On the</p>	F0282	F282I. It is the policy of Wesley Healthcare that medication is to be pulled/ verified/ administered per the rights of medication administration and standard nursing medication administration procedures. If a medication is not available it is to be pulled from EDK and pharmacy notified to send medication that evening or STAT if necessary. If pharmacy states they can not refill the medication due to insurance, notify DON or administrator to verify if medication cost may be covered by Wesley Healthcare. Medication is to be given without interruption. If a medication is not given, it is to be circled on the MAR and a reason for holding the medication must be given on the back of the sheet the medication is written on with date, time, reason and initials of nurse holding medication. Nursing must use judgment as to why medication was held and notify physician for further instruction. If a medication is noted to be held for an extended period of time, a medication error report must be filled out. The policy and procedure for Medication Administration was updated 6/11/2012.II. Nursing staff was	06/15/2012			

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	<p>back of the MAR, an entry on 5/13/12, indicated the artificial tears were not available, and the resident had left the artificial tears at her home and "no way to retrieve. "</p> <p>A nursing note, dated 5/13/12 at 3:00 p.m., indicated the resident had gone home for a visit with her son on 5/12/12, and left the eye drops at their home. The nursing note indicated the pharmacy was contacted, but the insurance would not pay for another bottle of eye drops for 1 month. There was no documentation the physician had been notified.</p> <p>A physician's progress noted, dated 5/8/12, indicated diagnoses including diabetic retinopathy left eye, tractional retinal detachment left eye, vitreous hemorrhage left eye, and diabetes mellitus. The plan on the progress note indicated to monitor for any worsening vision and notify physician if any changes, use artificial tears, and follow up visit in 8 weeks.</p> <p>The Director of Nursing Services was interviewed at 11:29 a.m. on 5/23/12. She indicated the resident had gone for a home visit on 5/12/12 with her son, and left her artificial tears at home. She indicated she was unaware the nurses were circling the</p>		<p>re-educated on the updated policy and procedure for medication administration on 6/14/2012.III. The DON or designee will monitor 100% of residents MARs once weekly for 2 months, 50% of residents MARs once weekly for 2 months and 25% of residents MARs once weekly for 2 months, to ensure medication is being given as ordered. Will be monitored quarterly at QA meetings for 2 quarters. IV. Date of completion is 6/15/2012.</p>		

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	<p>artificial tears as not available, and indicated the facility would have paid for the artificial tears so the resident could have received them. She indicated she considered this a medication error, and she should have been notified.</p> <p>3.1-35(g)(2)</p>				

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F0318 SS=D	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 4 residents reviewed who met the criteria for range of motion, received range of motion services. (Resident #32)</p> <p>Findings include:</p> <p>On 5/23/12 at 10:00 a.m., review of the clinical record for Resident #32 indicated she was admitted to the facility on 1/1/08 with diagnoses including, but not limited to, cerebral vascular zccident with right sided weakness, compression fracture, hypertension, aortic stenosis, atrial fibrillation and neuropathy.</p> <p>On 5/23/12 at 10:15 a.m., review of the resident's plan of care dated 4/3/12 indicated the following:</p> <p>Resident with diagnosis of cerebral vascular accident (CVA) and right sided weakness.</p>	F0318	F318I. It is the policy of Wesley Healthcare to ensure Restorative Therapy approaches and principles are aimed at improving, preventing deterioration, or maintaining residents' functional level and quality of life are integrated into the program and individual plan of care for all residents. Restorative Therapy Assessment is to be done upon admission to Wesley Healthcare and quarterly at minimum thereafter. The nursing staff determines the resident's potential to benefit from the program and the residents interest in participating. The nursing staff will also monitor for resident deterioration related to program and discontinue if necessary. Nursing staff is to be educated on Restorative Therapy upon employment with Wesley Healthcare.II. Nursing staff were educated on 6/12/2012 on the new policy and procedure for restorative therapy. All residents were reassessed for restorative therapy need on 6/14/2012. A restorative therapy assessment was made for nursing staff to be completed upon resident	06/15/2012	

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	<p>Resident will have no serious complications related to the CVA through next review.</p> <p>Approaches:</p> <p>Assist with ADL's as needed</p> <p>Keep call light with in reach.</p> <p>Therapy services as needed</p> <p>Monitor for declines per protocol.</p> <p>Notify MD as needed</p> <p>Medications as ordered.</p> <p>Observation and interview with the resident on 5/23/12 at 11:00 a.m. indicated the resident's right hand was contracted. The resident indicated she had a splint but did not wear it due to her choice.</p> <p>Review of therapy notes indicated the resident was not receiving any therapy services and was not in a restorative program.</p> <p>Interview with the Director of Nursing on 5/24/12 at 8:52 a.m., indicated, "Resident #32 was not on a restorative plan for range of motion but should be." The Director of</p>		<p>admission to Wesley Healthcare on 6/08/2012 and quarterly, at minimum.III. The DON or designee will monitor the restorative therapy program upon resident admission ongoing. The DON or designee will monitor restorative therapy program weekly for 1 month, once a month for 5 months and quarterly at QA meetings for 2 quarters. IV. Date of completion 6/15/2012</p>				

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	<p>Nursing indicated she had set up a restorative nursing program on 5/8/12 but she had not included Resident #32, because she thought the resident was in therapy.</p> <p>Review of Occupational Therapy Progress Reports indicated the resident was last treated in therapy from 1/11/12 through 1/17/12 for joint pain in her shoulder and muscle weakness.</p> <p>3.1-42(a)(2)</p>			

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F0322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a nurse checked placement of the gastrostomy tube in accordance with professional standards and facility policy prior to administering medications for 2 of 2 residents, who were observed to receive medications through the gastrostomy tube, Residents # 23 and #36.</p> <p>Findings include:</p> <p>1. During observation of the medication pass on 5/23/12 at 7:56 a.m., LPN #1 was administering medication through a gastrostomy tube to Resident #23. The nurse was observed to aspirate for stomach content with a syringe, and none was observed in the tube. The nurse then removed the syringe, again placed the syringe in the opening of the gastrostomy tube, and injected air into the tube. The nurse was</p>	F0322	<p>F322I. It is the policy of Wesley Healthcare to verify the physician's order to administer medications via G-tube/PEG. Verify PEG tube placement by instilling 20cc of air into the tube with the feeding syringe and listen with your stethoscope over the guest's stomach for a rush of air (note: never check placement by instilling a liquid).II. Nursing staff were re-educated on 6/14/2012 regarding proper technique for verifying PEG placement. On 5/30/2012 LPN#1 was given teachable moment on proper technique for verifying PEG placement. On 6/13/2012 the RN-LPN orientation was updated to include specific clinical competency for PEG placement verification.III. The DON or designee will monitor the technique of nursing staff for clinical competency of verifying PEG placement. If nursing staff member is found to be incorrect, DON will in-service or begin progressive discipline if applicable.IV. The DON or</p>	06/15/2012			

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	<p>observed to not use her stethoscope to listen for air to ensure the gastrostomy tube was in the stomach. The nurse then proceeded to administer the resident's medications through the tube.</p> <p>After LPN #1 completed administering Resident #23's medications, she was queried why she did not use a stethoscope to check placement of the gastrostomy tube. LPN #1 indicated she could hear the air without the stethoscope.</p> <p>2. During observation of a medication pass at 8:55 a.m., on 5/24/12, LPN#1 was preparing to give Miralax (laxative medication) through a gastrostomy tube to Resident #36. LPN #1 placed the syringe in the opening of the gastrostomy tube, and aspirated 5 cubic centimeters (cc) of stomach contents. The LPN then used the syringe to instill air to check for placement of the tube in the stomach. She did not use a stethoscope to listen for placement, and when interviewed, indicated, "lot of times" she could hear the "swish" without using the stethoscope, so she did not use the stethoscope.</p> <p>Review of the facility's policy for gastrostomy medication</p>		<p>designee will audit proper technique of verifying PEG placement for working nursing staff once weekly for 4 weeks, monthly for 5 months and quarterly at QA meetings for 2 quarters. V. Date of completion is 6/15/2012.</p>		

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	<p>administration, dated 3/07, and provided by the Director of Nursing Services on 5/24/12 at 3:30 p.m., indicated the following: "Verify tube placement by instilling 20 cc of air into the tube with the feeding syringe and listen with your stethoscope over the guests's stomach for a rush of air. (Note: Never check placement by instilling a liquid.)"</p> <p>3.1-44(a)(2)</p>			