

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/10/2012
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NAME OF PROVIDER OR SUPPLIER  HANOVER NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 1, 2, 3, 4, 5, 9, and 10, 2012</p> <p>Facility number: 000115 Provider number: 155208 AIM number: 100291080</p> <p>Survey team: Diana Sidell RN, TC Gloria Reisert MSW (October 1, 3, 4, 5, 9, and 10, 2012) Cheryl Fielden RN (October 1, 2, 3, 4, and 5, 2012) Jill Ross RN (October 2, 3, and 4, 2012)</p> <p>Census bed type: SNF/NF: 65 Residential: 8 Total: 73</p> <p>Census payor type: Medicare: 6 Medicaid: 52 Other: 15 Total: 73</p> <p>Residential sample: 7</p> <p>These deficiencies reflect state</p>	F0000	<p>Submission of this plan of correction does not constitute an admission agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</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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	findings cited in accordance with 410 IAC 16.2.  Quality review 10/17/12 by Suzanne Williams, RN			

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F0166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>Based on record review and interview, the facility failed to resolve a resident's grievance when she reported to Social Services her billfold and hearing aids were missing. This deficient practice affected 1 of 4 residents reviewed for personal property issues. (Resident #50)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #50 on 10/4/2012 at 3:30 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia, seizure disorder, vertigo, obstructive sleep apnea, and presbycusis (other disorder of the ear).</p> <p>During interview with the resident on 10/3/2012 at 3:00 p.m., she indicated she was missing her wallet containing her medical cards and 16.00 dollars since about 3 weeks ago, and also her hearing aids which occurred about 2-3 months ago. She indicated she had talked to the Social Worker and identified him by his name. She</p>	F0166	F0166 Requires that the facility shall resolve a residents grievance when reported . 1. Resident #50 was again interviewed and grievances noted with follow up action initiated accordingly.2. All residents have the potential to be affected, thus, the following corrective actions were taken. 3a. All staff were educated on how to complete a Report of Concern form on lost or stolen items and to forward to the administrator. 3b. The policy on "Lost or Stolen Items" attachment A was reviewed and no changes are indicated at this time. The Social Service Director was re-educated on the need to report to the resident or his/her legal representative the results of the investigation in the event the lost or stolen item is not recovered. The Social Service Director re-interviewed resident #50 and was told that she did have her billfold and her concern was only the hearing aids to be replaced. The Social Service Director completed a report of concern on resident #50 including the missing billfold which contained money and the missing hearing aids.The missing billfold was found in residents	10/31/2012	

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	<p>indicated he said they would look into the matter but nothing had been done. She also indicated she would like to get replacement cards and new hearing aids and didn't know she could.</p> <p>Review of the Quarterly Minimum Data Set [MDS] Assessments dated 3/30/12, 6/2/2012, and 10/5/2012 and the Annual MDS Assessment dated 8/20/12, indicated the resident was alert and oriented, was cognitively intact with no memory issues, had no mood or behavior issues, and had a BIMS [Brief Interview for Mental Status] score of 15 for all assessments, indicating no cognitive impairments. There also were no care plans to indicate the resident had a history of manipulating or making up stories.</p> <p>On 10/9/12 at 2:25 p.m. during an interview with the Social Worker and the Social Work Consultant, they indicated "Last time we interviewed her on 9/8/12, she answered 'no' to the question of missing items - never reported to me that she was missing her billfold or hearing aids."</p> <p>On 10/1/2012 at 9:45 a.m., the Administrator presented a copy of the facility's current policy on "Abuse"</p>		<p>room under pillow with money intact. Appointment made for the audio-gram for October 26th, resident is aware. Replacement of the hearing aids are pending an order from the audiologist. Audit completed throughout building and every resident's hearing aids are accounted for. 4. The administrator or designee will review social service documentation to ensure all missing or stolen items are addressed appropriately, including reporting of resolution to the resident/responsible party. Audits will be completed daily for one week then weekly for 4 weeks then monthly for 2 months, then quarterly to ensure continued compliance. Attachment B Findings of these audits will be reviewed during the facility's quarterly Quality Assurance and Assessment (QAA) meetings and the plan of action adjusted accordingly, if warranted.</p>		

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	<p>which included a policy on "Lost or Stolen Items." Review of the policy at this time included, but was not limited to: "Policy: It is the policy of this facility to conduct an investigation following the reporting of lost or stolen items. The Administrator or his/her designee shall be responsible for the investigative process. Procedure: 1) Should a resident or responsible party report an item as lost or stolen, a Report of Concern shall be completed and forwarded to the attention of the Administrator...5) The Administrator or his/her shall orally or in written form report to the resident or his/her legal representative the results of the investigation in the event the lost or stolen item is not recovered."</p> <p>The Administrator also presented a copy of the current policy on "Complaints and Grievances." Review of this policy included, but was not limited to: "Policy: This facility shall both investigate and respond to complaints and grievances made by an individual resident...This facility shall observe the right of the resident to voice a grievance without discrimination or reprisal, make prompt efforts to resolve grievances...Procedure:...An investigation will be conducted immediately by the Administrator or</p>			

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	<p>his/her designee as warranted..."</p> <p>On 10/9/2012 at 4:10 p.m., Nurse Consultant #2 presented a copy of the Social Worker's signed Job description dated 5/23/2012. Review of the Job Description at this time included, but was not limited to: "...Essential Job Functions:...12. respond promptly to notification that a resident has a social service concern warranting intervention...."</p> <p>3.1-7(a)(1)</p>			

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F0250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>Based on record review and interview, the facility failed to provide medically related social services to a resident when the discharge plan changed from going home after rehabilitation to needing to remaining in the nursing home for long term care. This deficient practice affected 1 of 1 resident who was reviewed for social services for discharge planning. (Resident #77)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #77 on 10/5/2012 at 10:30 a.m., indicated the resident was admitted on 4/25/2012 from the hospital and had diagnoses which included, but were not limited to: weakness, dementia, history of edema, chronic renal failure, depression, insulin dependent diabetes mellitus, gastrointestinal esophageal reflux disease, and atrial fibrillation.</p> <p>The 5/2/12 Initial Social Service Assessment indicated the D/C</p>	F0250	<p>F250 Provision of Medically related Social Service F250 requires that the facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psycho social well-being of each resident.</p> <p>1. Resident #77 and family voiced verbal understanding and agreement with the resident remaining in the nursing home for long term care. This discussion and determination has now been documented. 2 All residents have the potential to be affected by a revision in discharge plan following admission, thus, the following corrective actions have been taken. 3. The Social Service Director was re-educated on discharge planning and notification of family members and resident when a change occurs in the discharge plan from home to long term care. Along with the re-education of dating the care plan indicating when a care plan is discontinued and/or revised/updated. 4. The facility administrator or designee will review social service documentation addressing discharge planning for those</p>	10/31/2012	

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	<p>[discharge] plan was for the resident to have short term rehabilitation and then return home, and that both the resident and family expressed a desire and were supportive in discharging.</p> <p>Review of the 5/2/12 Admission MDS [Minimum Data Set] Assessment and the 6/5/2012 Quarterly MDS Assessment indicated the resident had no mood issues.</p> <p>Review of the 6/22/2012 Quarterly MDS Assessment indicated the resident was experiencing mood issues such as: little interest/pleasure in doing things; had trouble sleeping; was tired with little energy, and had a poor appetite. The resident also had poor long and short term memory issues.</p> <p>The 8/2/12 Quarterly Social Service Assessment indicated the discharge care plan was reviewed, and the resident was to remain long term care, and the resident and family did not express a desire nor were supportive toward discharge.</p> <p>Review of the care plan for "Discharge Plan," indicated a yellow line was put through it to indicate it was discontinued. Documentation</p>		<p>residents scheduled for MDS/careplan review weekly. Audits to be completed weekly for 4 weeks then monthly for 2 months, then quarterly to ensure continued compliance attachment C Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, as warranted.</p>		

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	<p>was lacking as to why the discharge plans had changed and the resident needed to remain in the nursing home nor a date of when the care plan was discontinued.</p> <p>On 10/10/2012 at 2:45 p.m. during an interview with the Social Worker, he indicated "I know I wrote a note regarding why she is not going home. If it's not in the binders on the unit, I'll have to look around."</p> <p>At 2:50 p.m., while accompanied by the Social Work Consultant, he was unable to locate documentation in Wing 3's binder (the unit the resident resided on) regarding the change in discharge planning. He indicated "Not sure if she started out on Wing 4 and if it would be in there, still." At 2:52 p.m., review of Wing 4's Social Service note binder failed to locate a Social Work note on the resident.</p> <p>On 10/10/12 at 5:00 p.m., the Social Work Consultant and Social Worker presented a copy of the 10/3/2012 Interdisciplinary Care Plan Conference Record and indicated that under the small section for "Discharge Planning", "LTC [long term care]" was marked, and the daughter was in attendance, and she was aware the resident was staying in the facility.</p>						

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	<p>On 10/9/2012 at 4:10 p.m., Nurse Consultant #2 presented a copy of the Social Worker's signed Job description dated 5/23/2012. Review of the Job Description at this time included, but was not limited to: "...Essential Job Functions:...4. Maintain social service records including initial psycho-social assessments, ongoing pertinent progress notes, quarterly notes and discharge plans...8. responsible for discharge planning and assisting families in placement arrangements...."</p> <p>3.1-34(a)</p>				

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F0272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      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 interview, the facility failed to accurately assess a resident's dental status. This affected 1 of 3 residents reviewed for dental status. (Resident</p>	F0272	F272 requires that the facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity	10/31/2012

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	<p># 96)</p> <p>Findings include:</p> <p>Resident #96's record was reviewed on 10/4/12 at 2:27 p.m. The record indicated Resident #96 was admitted with diagnoses that included, but were not limited to, acute coronary syndrome, angina, coronary artery disease, diabetes mellitus type 2, asthma, depression, difficulty swallowing, and chronic back pain.</p> <p>An Admission Minimum Data Set Assessment (MDS) dated 9/24/12 indicated Resident #96 was independent in cognitive skills for daily decision making, was independent after set up help for eating, and had no dental problems such as no natural teeth or tooth fragments, (was not edentulous [having no teeth]). The MDS failed to indicate the resident was edentulous.</p> <p>During an interview on 10/3/12 at 11:19 a.m., Resident #96 indicated he had chewing problems due to no teeth. He said someone came in and watched him eat and told him he was eating too fast. He also indicated he has been without teeth too long and he couldn't be fitted for them. He said he has no gum problems or mouth</p>		<p>y. The facility will ensure this requirement is met through the following measures. 1. Resident #96 was discharged to home on October 22nd. As a preventative measure, a call was made to Resident #96 and the resident asked if the facility could assist him with seeing a dentist or assist in getting dentures for him and he replied "no he has no problems with not having any teeth or dentures." 2. All residents have the potential to be affected, thus the following actions were taken. 3. All Licensed nurse and MDS nurses have been reeducated on the Admission Minimum Data set assessment section L and admission sheet attachment D, and importance of accuracy thereof which drives necessary care and potential referrals. MDS for resident #96 has been corrected and transmitted. 4. Administrative nursing staff/designee will review all residents MDS to verify accuracy for the completion of section L. Thereafter, newly completed MDSs will be compared to corresponding admission assessments weekly for 4 weeks, then monthly to ensure accuracy of MDS when compared to the admission assessment. The findings of these audits will be included and reviewed during the facility's quarterly Quality Assurance meetings and the plan of action</p>				

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	<p>sores. During this interview, the resident was observed to have neither natural teeth nor dentures.</p> <p>Physician's telephone orders dated 9/18/12 indicated: "S.T. (Speech Therapy) to eval[uate] &amp; treat for dysphagia, tx (treatment) 3X (times)/wk (week) X4 wks."</p> <p>A Speech Therapy Evaluation, dated 9/18/12, indicated Resident #96 was edentulous and was evaluated and treated for a diet texture analysis and had a goal to instruct resident on safe swallow protocol, to decrease the rate of eating, small sips, small bites, and to alternate the sips and bites.</p> <p>Physician's admission diet orders indicated a regular diet with no concentrated sweets and thin liquids.</p> <p>During an interview on 10/10/12 at 5:48 p.m., Corporate Nurse Consultant #1, the Director of Nursing, and MDS Coordinator #1 indicated when she assessed him, he had teeth. When they questioned the nurse who did the assessment, she said he had teeth, and they think he had teeth even though the original assessment indicated he didn't have teeth. The Corporate Nurse Consultant #1 indicated they use the</p>		adjusted accordingly, if warranted.				

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	Resident Assessment Instrument for their policy related to MDS assessments.  3.1-31(a) 3.1-31(c)(9)				

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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 record review, observation and interview, the facility failed to ensure care plan problems and approaches were complete for 3 of 31 resident care plans reviewed. (Residents #16, 50, and 96)</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #50 on 10/4/2012 at 3:30 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia, seizure disorder, vertigo, obstructive sleep</p>	F0279	F279 Development Comprehensive Care Plans 1.RE: Resident 16, 50, and 96. (79, as stated on the 2567, is not a identifier number) Care plans were reviewed and updated per Care Plan Development and Review Procedure policy. Attachment F to reflect plan of care for each resident. 2. All residents have the potential to be affected, thus the following corrective action was taken. 3. Policy reviewed and no revision to be made at this time, see Attachment G. The Nursing Staff and Social Service were re-educated on the Care Plan	10/31/2012	

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	<p>apnea, and presbycusis (other disorder of the ear).</p> <p>On 5/15/12, the resident had an Audiological exam in which her hearing aids were checked as the resident complained her hearing aids were not working. The Audiologist note indicated she cleaned both hearing aids and that the right hearing aid sounded fine but the left hearing aid required a new battery and had replaced a missing "vc cap."</p> <p>Review of the 8/30/12 care plan for "Alteration in Hearing" indicated the following approach was incomplete: "Be aware of assistive devices to be utilized by the resident such as: _____ (blank space) and be sure that the resident is using them and they are functioning properly."</p> <p>2. Review of the clinical record for Resident #16 on 10/9/2012 at 9:00 a.m., indicated the resident had diagnoses which included, but were not limited to: Maya Maya syndrome with right hemiplegia, and seizure disorder.</p> <p>Review of the Social Services care plans indicated the following problem issues were incomplete: - "9/4/2012 "Mood and Behavior" -</p>		<p>Development, including individualizing careplans by completing all necessary blanks/information, and Review Procedure Policy. The DON or designee will audit 10 resident careplans weekly for 4 weeks, then 10 residents every month to ensure care plans are complete and accurately reflect plan of care. Attachment H. The findings of these audits will be included during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted.</p>				

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	<p>Problem: resident presents with primary diagnosis of Bipolar D/O [disorder] and may exhibit any or all of the following mood and behaviors: _____ (blank space)." Approach - Psychiatric care with _____ (blank space)"</p> <p>- "8/29/12 with review date of 9/12/2012 "One - To - One's" - Resident requires one - to- one's with Social Services due to: _____ (blank space)"</p> <p>During an interview with the Social Worker on 10/9/2012 at 2:45 p.m., when shown care plans for Resident #16, he indicated the care plans were missing information.</p> <p>3. Resident #96's record was reviewed on 10/4/12 at 2:27 p.m. The record indicated Resident #96 was admitted with diagnoses that included, but were not limited to, acute coronary syndrome, angina, coronary artery disease, diabetes mellitus type 2, asthma, depression, difficulty swallowing, and chronic back pain.</p> <p>An Admission Minimum Data Set Assessment (MDS) dated 9/24/12 indicated Resident #96 was independent in cognitive skills for daily decision making, was</p>				

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	<p>independent after set up help for eating, and had no dental problems such as no natural teeth or tooth fragments, was not edentulous [without teeth]. The MDS failed to indicate the resident had no teeth.</p> <p>A "Resident Admission Assessment", dated 9/17/12, indicated Resident #96 was edentulous and did not indicate he had dentures.</p> <p>During an interview on 10/3/12 at 11:19 a.m., Resident #96 indicated he had chewing problems due to no teeth. He said someone came in and watched him eat and told him he was eating too fast. He also indicated he has been without teeth too long and he couldn't be fitted for them. He said he has no gum problems or mouth sores. During this interview, the resident was observed to have neither natural teeth nor dentures.</p> <p>Physician's telephone orders dated 9/18/12 indicated: "S.T. (Speech Therapy) to eval[uate] &amp; treat for dysphagia, tx (treatment) 3X (times)/wk (week) X4 wks."</p> <p>A Speech Therapy Evaluation dated 9/18/12 indicated Resident #96 was edentulous and was evaluated and treated for a diet texture analysis and</p>			

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	<p>had a goal to instruct resident on safe swallow protocol, to decrease the rate of eating, small sips, small bites, and to alternate the sips and bites.</p> <p>Physician's admission diet orders indicated a regular diet with no concentrated sweets and thin liquids.</p> <p>Review of care plans for Resident #96 failed to indicate a care plan that addressed the resident had no natural teeth and no dentures.</p> <p>During an interview on 10/10/12 at 5:48 p.m., Corporate Nurse Consultant #1, the Director of Nursing, and the MDS Coordinator #1 indicated when Resident #96 was assessed, he had teeth. When they questioned the nurse who did the assessment, she said he had teeth, and they think he had teeth even though the original assessment indicated he didn't have teeth.</p> <p>A policy and procedure for "Care Plan Development and Review Procedure", with a last review date of 9/28/12, was provided by the Assistant Director of Nursing on 10/10/12 at 7:00 p.m. The policy indicated, but was not limited to, "Purpose: To assure that a comprehensive care plan for each</p>			

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	<p>resident includes measurable objectives and timetables to meet the resident's medical and psychosocial needs. Policy: 1. An interdisciplinary team, in coordination with the resident and his/her family will develop a comprehensive care plan for each resident. 2. The comprehensive care plan has been designed to: Incorporate identified problem areas, Incorporate risk factors associated with identified problems, Build on the resident's strengths, Reflect treatment goals and objectives in measurable outcomes, Identify the professional services that are responsible for each element of care, Prevent the declines in the resident's functional status and/or functional levels...."</p> <p>3.1-35(a) 3.1-35(b)(1)</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 record review and interview, the facility failed to update the Social Service care plan for Discharge Planning when the resident's plans for discharge to home after rehabilitation had changed to long term care. This deficient practice affected 1 of 5 residents reviewed for social service care plans (Resident #77)</p> <p>Finding include:</p> <p>Review of the clinical record for Resident #77 on 10/5/2012 at 10:30 a.m., indicated the resident was admitted on 4/25/2012 from the</p>	F0280	F280 Right to Participate Planning Care-revise CP 1. Resident #77 and family voiced verbal understanding of remaining in the nursing home for long term care. This has now been documented in the record as well. 2 All discharged residents have the potential to be affected, thus the following actions have been taken. 3. The Social Service Director was re-educated on discharge planning, including documenting discussion and revising the corresponding careplan, as well as re-education of dating the care plan when there is a revision and/or a care plan is discontinued. 4. The	10/31/2012			

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	<p>hospital and had diagnoses which included, but were not limited to: weakness, dementia, history of edema, chronic renal failure, depression, insulin dependent diabetes mellitus, gastrointestinal esophageal reflux disease, and atrial fibrillation.</p> <p>The 5/2/12 Initial Social Service Assessment indicated the D/C [discharge] plan was for the resident to have short term rehabilitation and then return home, and that both the resident and family expressed a desire and were supportive in discharging.</p> <p>Review of the 6/22/2012 Quarterly MDS Assessment indicated the resident was experiencing mood issues such as: little interest/pleasure in doing things; had trouble sleeping; was tired with little energy, and had a poor appetite. The resident also had poor long and short term memory issues.</p> <p>The 8/2/12 Quarterly Social Service Assessment indicated the discharge care plan was reviewed and that the resident was to remain long term care, and the resident and family did not express a desire nor were supportive toward discharge.</p>		<p>facility administrator or designee will review social service documentation addressing discharge planning for applicable newly admitted residents and/or residents with a revised plan for discharge. Audits to be completed weekly for 4 weeks then monthly for 2 months, then quarterly to ensure continued compliance attachment I. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted.</p>				

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	<p>Review of the care plan for "Discharge Plan", indicated a yellow line was put through it to indicate it was discontinued. Documentation was lacking as to why the discharge plans had changed and the resident needed to remain in the nursing home nor a date of when the care plan was discontinued.</p> <p>During the final exit meeting with the facility on 10/10/2012 at 8:25 p.m., the Social Worker indicated there was a new care plan on the resident's chart which addressed adjusting to new placement.</p> <p>Upon review and in an interview with the Social Worker and the Social Worker Consultant on 10/10/2012 at 9:00 p.m., they indicated that after looking through the clinical record, they were unable to locate this care plan. The Social Work Consultant said one should have been written to address the resident having to remain in the facility.</p> <p>On 10/10/12 at 5:00 p.m., the Social Work Consultant and Social Worker presented a copy of the 10/3/2012 Interdisciplinary Care Plan Conference Record and indicated that under the small section for "Discharge</p>			

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	<p>Planning", "LTC [long term care]" was marked, and the daughter was in attendance, and she was aware the resident was staying in the facility.</p> <p>On 10/9/2012 at 4:10 p.m., Nurse Consultant #2 presented a copy of the Social Worker's signed Job description dated 5/23/2012. Review of the Job Description at this time included, but was not limited to: "...Essential Job Functions:...4. Maintain social service records including discharge plans. 5. Participate in comprehensive resident care planning..."</p> <p>3.1-35(c)(1) 3.1-35(d)(2)(B)</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 record review and interview, the facility failed to follow the physician's orders for fingersticks for blood sugar monitoring (Resident #77). This deficient practice affected 1 of 10 residents reviewed for following physician orders.</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #77 on 10/5/2012 at 10:30 a.m., indicated the resident was admitted on 4/25/2012 from the hospital and had diagnoses which included, but were not limited to: weakness, dementia, history of edema, chronic renal failure, depression, insulin dependent diabetes mellitus, gastrointestinal esophageal reflux disease, and atrial fibrillation.</p> <p>On 7/23/2012, the physician gave an order to "monitor F/S [finger sticks] QID [4 times a day] x [times] 2 weeks. Fax F/S results on 8-7-12 and f/u [follow up] on any new orders."</p>	F0282	<p>F282 Services by Qualified Persons/per care plan 1. Blood Glucose is being monitored for Resident #77 as ordered by the physician. Please note that the original document with omissions that was provided the surveyor was a copy of the blood glucose monitoring record which had been sent with the resident to the hospital (thus, was in the chart as record of documents which accompanied the resident). However, when reviewing, days after return, it gave the appearance there were blanks (in that it had been previously sent with the resident and was not the continued working copy). The second completed document was the record which continued with entries following the resident's return to the facility. Unfortunately, the reason for the two different records in question was identified after the survey, thus, was not adequately explained at the time of survey. 2. All residents requiring Blood Glucose monitoring are at risk, thus the following actions have been taken. Residents records of resident requiring blood glucose monitoring have been reviewed to ensure accuracy and</p>	10/31/2012			

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	<p>Review of the Blood Glucose Monitoring Record for the 7/23 to 8/6/2012 in the clinical record indicated the finger sticks were not performed on the following days</p> <ul style="list-style-type: none"> <li>- 7/24 - 2100 [9:00 p.m.]</li> <li>- 7/27 - none performed</li> <li>- 7/28 - none performed</li> <li>- 7/29 - none performed</li> <li>- 7/30 - none performed</li> <li>- 7/31 - none performed.</li> </ul> <p>Review of the nursing documentation for 8/7/2012 failed to indicate the physician had been notified of the results per his order. During an interview with Nurse Consultant #1 and the Minimum Data Set Coordinator on 10/10/2012 at 8:55 p.m., they indicated they had looked at the nursing notes and were unable to show if the physician had been notified the fingersticks were not completed per his order.</p> <p>During the final exit meeting with the facility on 10/10/2012 at 9:05 p.m., the DoN [Director of Nursing] and ADoN [Assistant DoN] presented a copy of the same Blood Glucose Monitoring Record in which all the days were filled in.</p> <p>When queried during an interview with both nurses at this time as to</p>		<p>performance in accordance with the physician's order. 3. Licensed nursing staff have been re-educated on completion of physician's orders for finger sticks for blood glucose monitoring, as well as notification of physician when it is identified that physician's orders have not been followed, see Attachment J. 4. The DON or designee will monitor Blood Glucose records daily, Monday thru Friday, for 2 weeks, then twice weekly for 4 weeks, then weekly for 3 months, then quarterly to ensure continued compliance. Should non-compliance be noted, re-education and disciplinary action, if warranted, shall be initiated, see Attachment K. The findings of these audits will be included during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted.</p>				

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	<p>where this completed record had been and why it was not on the clinical record, the DoN indicated she could not explain why the Blood Glucose Record with the blanks was in the current clinical record and that she had just happen to find the completed one in the overflow file in the Medical Records Office when she now looked. She further indicated the physician had been notified of the results.</p> <p>3.1-35(g)(2)</p>			

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F0313 SS=D	<p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>Based on record review and interview, the facility failed to ensure a resident was evaluated and had received replacement hearing aids after reporting her hearing aids were missing for over 2 months. This deficient practice affected 1 of 1 resident reviewed for hearing. (Resident #50)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #50 on 10/4/2012 at 3:30 p.m., indicated the resident had diagnoses which included, but were not limited to: dementia, seizure disorder, vertigo, obstructive sleep apnea, and presbycusis (other disorder of the ear).</p> <p>During an interview with the resident on 10/3/2012 at 3:00 p.m., she indicated she was missing her</p>	F0313	F313 Treatment/Devices to Maintain Hearing/Vision. An audiological appointment has been scheduled for Resident #50. The facility will pursue to ensure the resident is evaluated and receives replacement hearing aides, if warranted per exam 2. All residents have the potential to be affected, thus the following actions have been taken. 3 All staff were educated on how to complete a Report of Concern form Attachment L on lost or stolen items and to forward to the administrator. While facility was aware that the resident had hearing aids, the facility was never made aware they were missing by resident or family. Routine resident interviews by Social Services with this resident never revealed that they were missing. Resident keeps valuables in a lock box and does not allow staff to open it to inventory items. Resident rarely wore hearing aids and evidenced no diminished capacity to hear	10/31/2012	

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	<p>hearing aids which occurred about 2-3 months ago. She indicated she had talked to the Social Worker and identified him by his name. She indicated he said they would look into the matter but nothing had been done. She also indicated she would like to get new hearing aids and didn't know she could.</p> <p>During the interview with the resident, she would frequently turn her head to hear better out of the left ear - no hearing aides were observed in her ears - and requested some questions repeated as she did not hear them.</p> <p>Review of the Quarterly Minimum Data Set [MDS] Assessments dated 3/30/12, 6/2/2012, and 10/5/2012 and the Annual MDS Assessment dated 8/20/12, indicated the resident was alert and oriented, was cognitively intact with no memory issues, had no mood or behavior issues, and had a BIMS [Brief Interview For Mental Status] score of 15 for all assessments indicating no cognitive impairment. There also were no care plans to indicate the resident had a history of manipulating or making up stories.</p> <p>During interviews with CNA #5 and #6 on 10/5/2012 at 12:10 p.m., they</p>		<p>without them. Therefore staff did not report. Facility has scheduled an appointment with the audiologist for Friday, October 26, 2012. Resident #50 hearing will be evaluated and new hearing aids will be ordered based upon that evaluation. All residents with hearing aides have been identified to ensure use of the same is clearly communicated to staff, as well as addressed on the respective careplan. In this manner, staff will monitor for presence and use during daily care. 4a. The Administrator or Designee will review social services documentation to ensure all missing and stolen items are addressed appropriately and timely on an ongoing basis. Should there be a loss of devices to maintain hearing/vision, the same will be addressed weekly until resolution is obtained (i.e., exam, repair, replacement, etc.). Continued compliance with the provision of proper treatment and assistive devices to maintain vision and hearing abilities will be reported to the facility's quality assurance and assessment meetings and a plan of action adjusted accordingly, if warranted.</p>		

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	<p>indicated that hearing aids were locked up in the nursing cart - not kept at patient's bedside. They indicated she does not wear them as she makes them repeat themselves and didn't know why she doesn't wear them.</p> <p>During an interview with the Activity Director at 12:15 p.m. on 10/5/2012, she indicated " the resident has selective hearing - never misses a number in bingo, and I think just got a new hearing aide not long ago; sometimes she'll wear it, and others she will not, don't know why. Have not really seen them in her ears but she can do very well at activities and doesn't miss a thing."</p> <p>At 1:30 p.m., LPN #5 indicated "she had hearing aids and they were really old and I think broke. Not sure where they are now. She has these that are actually amplifiers not hearing aids, but she calls them hearing aids. Review of the med cart, failed to locate them in the med cart...let me look into what might have happened to the old ones."</p> <p>On 10/9/12 at 2:25 p.m. during an interview with the Social Worker and the Social Work Consultant, they indicated "Last time we interviewed</p>						

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	<p>her on 9/8/12, she answered 'no' to the question of missing items - never reported to me that she was missing her hearing aids. She is on the list to be seen by the audiologist sometime this month when [name of audiological group] gives us a date. Will have to check when last seen. To us, she refers to her amplifiers as her hearing aids. "</p> <p>On 10/9/2012 at 1:50 p.m., LPN #5 indicated she spoke with the resident and the MDS [Minimum Data Set] staff did an assessment on her; she is able to hear with minimal difficulty. The MDS coordinator indicated the Social worker has the resident on the list to see the audiologist next time they come in - every 2 months or so.</p> <p>A 8/30/12 Care Plan - "Alteration in Hearing" was noted: "Goal - the resident will have acts adapted to hearing disabilities daily. Approaches: be aware of severity of hearing disability and adapt as needed. Be aware of of assistive devices to be utilized by the resident such as _____(blank) and be sure that the resident is using them and they are functioning properly."</p> <p>On 5/12/2012, the resident had an Audiological exam in which the</p>			

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	<p>Audiologist checked the resident's hearing aids because the resident complained the hearing aids were not working. Both hearing aids were cleaned and the right one was noted to sound fine, but the left one required a new battery and the missing "vc cap" was replaced.</p> <p>Nursing notes between 5/1 and 10/3/2012 failed to indicate documentation of the resident wearing her hearing aids or reports of them being missing.</p> <p>3.1-39(a)(1)</p>			

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F0371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on record review, observation and interview, the facility failed to distribute and serve food under sanitary conditions by ensuring proper handwashing and glove use occurred during meal service for 2 of 2 meal observations. This deficient practice had the potential to affect 73 of 73 residents currently residing in the facility and 7 of 7 Residential residents.</p> <p>Findings included:</p> <p>1. During the lunch meal service observation on 10/3/2012 between 12:00 p.m. and 12:40 p.m., the following was observed: - 12:04 p.m. - the Administrator came into kitchen from the assisted dining room, put gloves on from his pocket without washing his hands prior, and began scooping ice into glasses and pour iced tea for trays. He then grabbed the ice pitchers with spouted lids on them from top (hand covered lid), took the lids off to fill with ice.</p>	F0371	<p>F371 Food Procure, Store/Prepare/Serve- Sanitary 1. Applicable staff members were re-educated as to proper handwashing and glove use following the identified observations during which concern was noted. 2. All residents have the potential to be affected, thus, the following corrective actions were taken. 3. "Use of Gloves" policy was reviewed and no changes made. Attachment M and "Handwashing policy" was reviewed and no changes made, see Attachment N. Dietary Staff and the Administrator were in-serviced on 10/5/12 regarding distribution and serving of food under sanitary conditions by ensuring proper handwashing and glove use during meal service. 4. As a means of quality assurance, a dietary designee will be responsible for completing a monitoring sheet, conducting observations at least five times weekly. Should concern be noted, re-education shall be conducted (See attachment O). Each meal (Breakfast, Lunch, Supper) will be observed at least one time per</p>	10/31/2012	

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	<p>Although the pitchers had handles, the Administrator failed to use them.</p> <p>- 12:17 p.m. - the Administrator wiped down a food cart with a rag from the disinfectant bucket, disposed of his gloves, went to put new ones on, stopped, put his gloves on top of towel dispenser, washed hands, turned handles off with his shoulder and then dried his hands with a paper towel, then put the gloves on from on top of the paper towel dispenser.</p> <p>- 12:30 p.m. - the Administrator returned to the kitchen from the nursing units with a tray of pureed cookies and gloved hands. He then went into dish room to wash the metal heat pallets as they were dropped on the floor. He touched the dishwasher rack with his gloved hands, removed and threw them away and put new ones on - no washing hands in between. He then picked up the dish top lids and moved them over to the cook to cover the dishes to the trays.</p> <p>- 12:35 p.m. - the Administrator retrieved the heated pallets from dish room and gave them to the cook.</p> <p>- 12:38 p.m. - The Administrator then took the food cart to wing 3 with his gloves still on his hands.</p>		<p>week. Results of the audits/observations and corrective actions taken will be reviewed during the facility's quarterly quality assurance meeting and the above plan will be altered accordingly, if warranted.</p>				

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	<p>- 12:40 p.m. - the Administrator then returned to the kitchen from delivering the hall food cart, removed his gloves in the dishroom and donned new ones - no handwashing observed; then gathered glasses for the dining room trays.</p> <p>2. During the supper meal service observation on 10/4/2012 between 5:00 p.m. and 12:40 p.m., the following was observed:</p> <p>- 5:19 p.m. - the Administrator began pouring/prepping cups for coffee - had washed hands before task; but then went and retrieved cup lids from a cabinet in the kitchen and placed gloves on without washing his hands.</p> <p>- 5:24 p.m. - Dietary aide #1 was observed to rub her nose with her hand and resumed working the tray line.</p> <p>- 5:25 p.m. - Dietary aide #1 was observed to take a marker out of her pocket, marked the tops of cup lids, and then put it back down into her pocket and resumed tray line.</p> <p>- 5:29 p.m. - Dietary aide #1 took the food cart out to floor wing 2; open the door from the dining room to the kitchen (2 residents were observed to</p>						

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	<p>have opened the door previously), and resumed tray line.</p> <p>- 5:33 p.m.- Dietary aide removed a tray from the stack, and touched the food on the tray and resumed working the tray line.</p> <p>- 5:41 p.m. - Dietary aide #1 took the food cart to wing 4, came through the door (same as above) and resumed the tray line.</p> <p>- 5:51 p.m. - Dietary aide #1 returned from wing 3 through the dining room door and began making coffee for residents, pouring, and touching inside of cups with fingers as she set them up.</p> <p>No handwashing was observed by Dietary aide #1 during any of the above observations.</p> <p>On 10/5/2012 at 10:00 a.m., the Consultant Dietitian presented a copy of the facility's current policy on "Glove Use &amp; Meal Service". Review of the policy at this time included, but was not limited to: "...Procedure:...3. hands must be washed frequently per the handwashing policy...5. hands should be washed thoroughly between tasks...9. Hands must be washed and completely dried prior to</p>						

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	<p>putting on a pair of gloves. 10. If an employee...leaves and enters the kitchen, touches equipment handles... or touches any part of their body - they MUST immediate wash their hands...12...Gloves must be discarded and hands must be washed when moving from the soiled to clean areas..."</p> <p>3.1-21(i)(3) 5-5.1(f)</p>			

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F0441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F0441	441 Infection Control, prevent spread, Linens. 1. LPN #1 was	10/31/2012			

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	<p>ensure their infection control policy related to glove use was followed during blood glucose monitoring and insulin injection, for 1 of 2 residents randomly observed. (Resident #21)</p> <p>Findings include:</p> <p>During an observation on 10/4/12 at 3:48 p.m., LPN #1 did a finger stick for blood glucose monitoring for Resident #21 and did not wear gloves, then gave an insulin injection and failed to wear gloves.</p> <p>During an interview on 10/4/12 at 4:27 p.m., LPN #1 indicated she didn't wear gloves because they didn't have her size out.</p> <p>A policy and procedure for "Use of Gloves", last reviewed on 9/28/12, was provided by Corporate Nurse Consultant #1 on 10/4/12 at 4:33 p.m. The policy indicated, but was not limited to, "Policy: Gloves are worn to provide a protective barrier and prevent gross contamination of the hands when touching blood, body fluids, secretions, excretions, mucus membranes and non-intact skin. Purpose: 1. Gloves are worn to reduce the likelihood that microorganisms present on the hands of personnel will be transmitted to</p>		<p>re-educated upon notification of the observation. Glove supply was assessed to ensure appropriate size gloves were available for use. 2. As all residents and staff could be potentially affected, the following actions were taken 3. "Use of Gloves" Policy (Attachment P) reviewed and no revisions are necessary at this time. All Licensed Staff re-educated on the "Use of Gloves" policy and LPN#1 was educated immediately on where glove supplies are kept. 4. The DON or designee will complete observations for correct glove use as per policy daily for one week then weekly for 4 weeks then monthly for 2 months, then quarterly to ensure continued compliance. Should non-compliance be observed, re-education and/or disciplinary action will be initiated as warranted, see Attachment Q. Findings of these audits will be reviewed during the facility's quarterly Quality Assurance and Assessment (QAA) meetings and the plan of action adjusted accordingly, if warranted.</p>		

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	<p>residents during invasive or other resident care procedures that involve touching resident's mucous membranes and non-intact skin. 2. Gloves are worn to reduce the likelihood that hands of personnel contaminated with microorganisms from a resident or a fomite (any substance that absorbed and transmits infectious material) can transmit these microorganisms to another resident...4. Gloves should be used for hand contaminating activities, handling soiled linen, when touching blood, body fluids, secretions excretions, mucous membranes and non intact skin...."</p> <p>3.1-18(b)</p>			

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F0507 SS=D	<p>483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.</p> <p>Based on record review and interview, the facility failed to ensure physician ordered lab results were filed in the residents' clinical records in a timely manner. This deficient practice affected 2 of 10 residents reviewed for lab results. (Residents #77 and 16)</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #77 on 10/5/2012 at 10:30 a.m., indicated the resident was admitted on 4/25/2012 from the hospital and had diagnoses which included, but were not limited to: weakness, dementia, history of edema, chronic renal failure, depression, insulin dependent diabetes mellitus, gastrointestinal esophageal reflux disease, and atrial fibrillation.</p> <p>Review of the physician orders for August and September 2012 indicated the resident had the following lab orders with results not available in the clinical record at the</p>	F0507	<p>F 507 Lab Reports in Record in Record-Lab name/address1.Lab results were obtained and were filed in the respective medical records for residents #77 and #16.2. All residents have the potential to be affected, thus, the following actions have been taken. An audit has been conducted of all labs ordered in the last 30 days to ensure lab results are found on the respective medical record.3. All licensed nursing staff were educated on the filing of labs/xrayresults on chart after contacting physician and family. 4. DON or Designee will track labs ordered audit daily on scheduled days of work to ensure that labs/xray results are placed in charts in a timely manner for review following physician notification. Should non-compliance be noted, corrective action shall be taken. Continued compliance with the filing of lab/x-ray results on the medical record will be reported to the Quality Assurance Committee during quarterly meetings.</p>	10/31/2012	

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	<p>time of the chart review:</p> <ul style="list-style-type: none"> <li>- 9/24/12 - PT/INR to be drawn on 10/1/12</li> <li>- 8/29/12 - Chem 7 in 2 weeks to be drawn on 9/12/12</li> <li>- 8/29/12 - Routine Chem 7 every 2 weeks - the last Chem 7 was done on 8/27/2012.</li> </ul> <p>2. Review of the clinical record for Resident #16 on 10/9/2012 at 9:00 a.m., indicated the resident had diagnoses which included, but were not limited to: Maya Maya syndrome with right hemiplegia, and seizure disorder.</p> <p>Review of the Monthly physician orders signed on 10/3/12 indicated the resident had orders for labs which were not available in the clinical record during the record review:</p> <ul style="list-style-type: none"> <li>- CBC monthly - August and September results not available</li> <li>- BMP monthly - August and September results not available</li> </ul> <p>During interview on 10/10/12 at 5 p.m., Nurse Consultant #1 indicated she believed the labs were done, but sometimes they are put on the clipboard waiting for the physician to review before they are placed in the chart. She also indicated she had to</p>						

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	<p>contact the lab to fax over new copies of the results of some of the labs.</p> <p>3.1-49(f)(4)</p>				

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F0513 SS=D	<p>483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED</p> <p>The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services.</p> <p>Based on record review and interview, the facility failed to file a chest X-ray result report in the clinical record in a timely manner in order for the physician to review. This deficient practice affected 1 of 3 residents reviewed for timely X-ray result reports. (Resident #12)</p> <p>Finding includes:</p> <p>Review of the clinical record for Resident #12 on 10/5/2012 at 9:00 a.m., indicated the resident was an Assisted Living resident who had been hospitalized due to a TIA [transient ischemic attack] and subsequently admitted to the health center on 8/2/12.</p> <p>On 9/17/2012, the physician gave an order for the resident to have a chest X-ray due to decreased oxygenation level and having some shortness of breath and edema. Documentation of the results were lacking in the clinical record.</p> <p>During review of the clinical record, the following physician progress note</p>	F0513	<p>F513 x-Ray/diagnostic report in record-sign/dated.1. Resident #12's x-ray result was filed on the respective chart. 2. All residents have the potential to be affected, thus the following actions have been taken. A complete audit was completed to ensure all x-ray/diagnostis results were on the charts for those residents for whom said testing has been ordered. 3. All licensed nursing staff were educated on the filing of labs/exray results on chart after contacting physician and family. 4. DON or Designee will track newly ordered x-rays and diagnostic procedureds and audit daily on scheduled days of work to ensure that labs/xray results are placed in charts in a timely manner for review following physician notification. Continued compliance will be reported to the Quality Assurance Committee during quarterly meetings.</p>	10/31/2012	

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	<p>was written: "9/26/12 - MD Note - patient with cough/some discolored sputum reported. Swelling improved. Appetite has not been very good by report. Increase Coumadin, obtain recent chest X-ray result, obtain sputum culture."</p> <p>Although the Nurse Consultant #1 on 10/10/12 at 4:00 p.m. indicated the X-ray was done, the results were still not in the clinical record until she presented it at this time. She also indicated the physician was aware of the results and could not account for why he wrote in his 9/26/2012 note that he needed the facility to obtain the results.</p> <p>The Nurse Consultant also indicated X-ray results would not be placed into the clinical record until the physician had reviewed them and would remain on a clip board until they were reviewed.</p> <p>On 10/10/2012 at 4:45 p.m., the DoN [Director of Nursing], ADoN [Assistant DoN], and Nurse Consultant #1 indicated "the labs come into the front office and the office manager then faxes them to each of the units for the nurses to review and notify the physician."</p>						

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure therapy notes and evaluations were accessible for 2 of 3 residents reviewed for rehabilitation (Residents #12 and #44) and documentation in the Social Service binder and 1 of 2 Wing 3 Nursing Notes binders were readily available for review.</p> <p>Findings included:</p> <p>1. Review of the clinical record for Resident #12 on 10/5/2012 at 9:00 a.m., indicated the resident was an Assisted Living resident who had been hospitalized due to a TIA [transient ischemic attack] and subsequently admitted to the health center on 8/2/12 for PT [physical therapy] and OT [occupational</p>	F0514	F514 Requires that the facility must maintain medical records in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the state; and progress notes. 1. Records for therapy provided residents #12 and #44 are readily accessible to staff. 2. All residents have the potential to be affected, thus the following corrective action have been taken. All therapy, Social Service notes, and Nurses notes were located and returned/placed	10/31/2012			

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	<p>therapy].</p> <p>Review of the clinical record's Therapy section tab failed to locate documentation by PT and OT, including an evaluation, daily and weekly progress notes.</p> <p>During an interview with CNA #4 on 10/5/2012 at 9:25 a.m., the CNA indicated if a resident was on active case load, then all the notes would remain in the therapy office until the resident was finished with therapy. Then they would go onto the clinical record. The CNA also indicated she understood that the notes were not accessible to anyone who may want them after therapy left for the day, as the office would then be locked.</p> <p>2. Review of the clinical record for Resident #44 on 10/5/2012 at 9:50 a.m., indicated the resident was admitted to the health center on 7/27/2012 after an acute hospitalization for chronic obstructive pulmonary disease, abdominal pain, kidney stones, prostate cancer, and hernia repair and had orders for PT, ST [speech therapy] and OT.</p> <p>Review of the clinical record's Therapy section tab failed to locate documentation by PT, ST and OT,</p>		<p>on appropriate unit. Therapy notes consisting of daily updates were put in binders on each unit readily available for review and updated daily. Social Service Binders were put on each unit consisting of accurate documentation with Social Service notes. 3. Social Service Director was re-educated on completion of Social Service notes to be in binders on each wing. Therapy department educated on daily therapy notes to be readily available for review. Nursing staff were educated for nurses note binders to remain on units while documenting. 4. The DON or her designee will observe to ensure medical records remain accessible to staff for review on scheduled days of work daily for 4 weeks, then weekly for 4 weeks, then bi-weekly for 4 weeks, then monthly for 2 months, see Attachment T. Should non-compliance be noted, re-education shall be conducted. The findings of these audits will be reviewed during the facility's quarterly Quality Assessment and Assurance meetings and the plan of correction adjusted accordingly, if warranted.</p>		

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	<p>including an evaluation, daily and weekly progress notes.</p> <p>During an interview with the Assistant Director of Nursing [ADoN] on 10/9/2012 at 11:10 a.m., she indicated "We keep a UR [utilization review] book at the nursing station where we meet weekly with therapy and go over what they have done and progress/lack of and document in it, but therapy assessments and progress notes are not in this book, as they are in the therapy office."</p> <p>3. During the clinical record reviews on 10/5/2012 at 10:10 a.m., the Social Service binder was unable to be located. At 10:20 a.m., Nurse Consultant #1 indicated Wing 4 was where the Social Service binder was usually located, and she had made sure yesterday the binder was there. She also indicated she had told the Social Worker to take everyone's notes out of the main binder and to put them at each unit where the resident resides.</p> <p>At 10:25 a.m., one of Wing 3's nursing notes binder was unable to be located. At 10:30 a.m., the DoN indicated "The nurse who works on 3 sometimes will take it to the nursing station on Wing 4, and I know it is in</p>				

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R0000	<p>that office as I just saw it there." At this time, LPN # 2 retrieved Wing 3's Nursing documentation book which was located behind a locked door on Wing 4.</p> <p>At 11:46 a.m., the Social Service binder was located on Wing 4 and was brought to Wing 3. Observation of the binder at this time indicated Social Service notes for everyone in the building was in this binder with a note on front "Notes are NOT to be removed from Wing 4."</p> <p>3.1-50(a)(3)</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R0000	<p>Submission of this plan of correction does not constitute an admission agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	

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R0214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to ensure the semi-annual assessments were signed by the licensed nurse who completed the assessments for 5 Residential residents in a sample of 7 Residential residents. (Residential residents R2, R4, R5, R6, and R7.</p> <p>Findings included:</p> <ol style="list-style-type: none"> <li>During the review of the clinical record for Residential resident R2 on 10/10/2012 at 11:48 a.m., a 6/11/2012 and a 7/10/12 Level Of Service Assessment/Evaluation were located in the Assessment section. Documentation was lacking of the assessments having been signed as to who completed them.</li> <li>During the review of the clinical record for Residential resident R4 on 10/10/2012 at 12:05 p.m., a 4/9/2012 Level Of Service Assessment/Evaluation was located in the Assessment section.</li> </ol>	R0214	R 2141. R2, R4, R5, R6, and R7 assessments were reviewed and applicable nurse identified and addressed as to failure to sign the completed assessments 2. All residents have the potential to be affected, thus the following actions have been taken. All records were audited to ensure the signature of licensed nurse was present to indicate the completion of the assessment. 3. Level of Service Assessment/Evaluation Form was revised by adding a signature line for the Licensed Personnel to sign, in an effort to ensure compliance with signature of the licensed nurse completing said assessment. See attachment U . 4. The Administrator will audit each Level of Service Assessment/Evaluation Form upon completion in an effort to verify continued compliance with the signing of the completed assessment.	10/31/2012	

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	<p>Documentation was lacking of the assessment having been signed as to who completed it.</p> <p>3. During the review of the clinical record for Residential resident R5 on 10/10/2012 at 11:15 a.m., a 5/29/12 and a 7/06/12 Level Of Service Assessment/Evaluation were located in the Assessment section. Documentation was lacking of the assessments having been signed as to who completed them.</p> <p>4. During the review of the clinical record for Residential resident R6 on 10/10/2012 at 11:35 a.m., a 4/9/2012 and a 7/6/12 Level Of Service Assessment/Evaluation were located in the Assessment section. Documentation was lacking of the assessments having been signed as to who completed them.</p> <p>5. During the review of the clinical record for Residential resident R7 on 10/10/2012 at 11:00 a.m., a 7/6/12 Level Of Service Assessment/Evaluation was located in the Assessment section. Documentation was lacking of the assessment having been signed as to who completed it.</p> <p>During an interview with LPN #2 on</p>				

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	<p>10/10/2012 at 11:05 a.m., she indicated it was the Director of Nursing's responsibility to complete the Level of Service Assessments.</p> <p>On 10/10/2012 at 8:40 p.m., the Assistant Director of Nursing [ADON] presented a copy of the facility's current policy on "Evaluation Of Individual Resident Needs." Review of this policy at this time, included, but was not limited to: "...Assessments will be completed by a licensed nurse..."</p> <p>During the final exit meeting with the Administrator on 10/10/12 at 8:45 p.m., he indicated he would make sure there was a line at the end of the assessment to ensure the nurse signed it.</p>				

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R0356	<p>410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following:</p> <ol style="list-style-type: none"> <li>(1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth.</li> <li>(2) The resident ' s hospital preference.</li> <li>(3) The name and phone number of any legally authorized representative.</li> <li>(4) The name and phone number of the resident ' s physician of record.</li> <li>(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.</li> <li>(6) Information on any known allergies.</li> <li>(7) A photograph (for identification of the resident).</li> <li>(8) Copy of advance directives, if available.</li> </ol> <p>Based on record review and interview, the facility failed to ensure the emergency files contained sufficient information (correct apartment number, physician name and/or phone numbers, hospital preference and emergency contact information) in the event of an emergency for 3 of 7 residential records (Residential Residents R3, R6 and R7).</p> <p>Findings included:</p> <p>Review of the current Emergency File Book for the Residential residents on 10/10/2012 at 10:55 a.m., indicated</p>	R0356	R 356 1. Resident #3 Emergency file face sheet was updated to have the current apartment number, emergency contact, name and phone number of the physician, and hospital preference. Resident #6 Emergency file current apartment number was completed on file. Resident #7 emergency file was updated with the correct apartment number and hospital preference. 2. Emergency files of all residents reviewed to verify all necessary information in place within said files. 3. Medical Records coordinator was re-educated on the medical records admission process and required elements of the	10/31/2012	

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	<p>the following residents' files were missing information:</p> <ol style="list-style-type: none"> <li>1. Residential resident R3 was admitted to Assisted Living on 2/19/2011. The Emergency file was missing the entire face sheet which was to have listed the current apartment number, emergency contacts, name and phone number of the physician, and hospital preference.</li> <li>2. Residential resident R6 was admitted to Assisted Living on 12/23/2010. The Emergency file had the wrong apartment number listed.</li> <li>3. Residential resident R7 was admitted to Assisted Living on 7/1/2011. The Emergency file had the wrong apartment number listed and was missing a hospital preference.</li> </ol> <p>During the final exit meeting on 10/10/12 at 8:25 p.m. with the Administrator, he indicated this information should have been included in the residents' emergency files to ensure they were accurate and up to date.</p>		<p>emergency file. 4. The DON or Designee will audit medical records upon each new AL admission to ensure the completion of each emergency file, see Attachment V.</p>		