

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/31/2014
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NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: March 24, 25, 26, 27, 28 and 31, 2014</p> <p>Facility Number: 011596 Provider Number: 155769 AIM Number: 200901690</p> <p>Survey Team: Tina Smith-Staats, RN, TC Karen Lewis, RN Ginger McNamee, RN Toni Maley, BSW (March 24, 25, 26, 27 and 28, 2014)</p> <p>Census Bed Type: SNF: 44 SNF/NF: 10 Residential: 32 Total: 86</p> <p>Census Payor Type: Medicare: 21 Medicaid: 7 Other: 58 Total: 86</p> <p>Residential sample: 8</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p>	F000000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey on March 31, 2014. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES			

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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	<p>(INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of laboratory results for 1 of 5 residents reviewed for unnecessary medications. (Resident #46)</p>	F000157	<p><b>F 157</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #46 has been discharged from the campus.</p>	04/30/2014

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	<p>Findings include:</p> <p>The clinical record for Resident #46 was reviewed on 3/26/14 at 10:15 a.m. Diagnoses for Resident #46 included, but were not limited to, hypertension, depression, congestive heart failure, humerus fracture, and chronic renal disease.</p> <p>PT/INR (prothrombin time/international Normalized Ratio) laboratory (lab) results completed on 1/27/14, 2/11/14, and 2/27/14 were filed in the resident's clinical record. All results for each PT/INR were flagged as high by the testing facility. A Comprehensive Metabolic Panel (CMP) and Complete Blood Count (CBC) completed on 3/4/14 was filed in the resident's clinical record. The lab results had multiple items flagged as high and low by the testing facility. Each lab result had been stamped. The stamp includes the following information: MD notified and date, family notified and date, new orders, and a place for the initials of staff. The 1/27/14 lab result had the name of the doctor, date and initials completed. The 2/11/14 lab result had the name of the doctor and date completed. The 2/27/14 lab result had the name of the doctor, date and initials completed. The 3/4/14 lab result had the stamp only with no information completed. The nurses notes from 1/27/14, 2/11/14, 2/27/14, and 3/4/14 did not contain any documentation related to lab results and physician notification.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 3/28/14 at 9:46 a.m., additional information was requested related to the physician notification of the lab results from 1/27/14, 2/11/14, 2/27/14, and 3/4/14. The ADoN indicated any "critical" or "alert" lab values received are</p>		<p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents with abnormal lab results for the past 14 days to ensure MD was notified of the results.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Physician Notification Guidelines</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 5 months to ensure compliance: review 5 residents per hallway with abnormal lab results to ensure MD was notified.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then</p>				

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	<p>called to the physician. Any other lab results are stamped, faxed to the physician, and placed in a file for physician review. She indicated if the lab result was stamped then the physician had been notified. She indicated the facility does not receive a confirmation from the physician's office after faxing results. She further indicated she did not know why the physician's initials or signature were not on the lab results to acknowledge having seen the lab results for 3/4/14.</p> <p>During an interview with the ADoN on 3/28/14 at 12:54 p.m., she indicated she had no further information to provide regarding the physician notification of labs for Resident #46.</p> <p>Review of the current facility policy, dated 12/6/07, titled "PHYSICIAN NOTIFICATION GUIDELINES," provided by the DoN on 3/28/14 at 8:00 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care.</p> <p>PROCEDURE:...</p> <p>...7. Diagnostic test results require a response from the physician noting they have reviewed the test results., Test results out of normal range should note whether or not treatment is desired....</p> <p>...9. If the facility has not had a response to abnormal test results or request for physician intervention within 121 hours or normal test results within 72 hours, the nurse on duty will</p>		randomly thereafter for further recommendation.				

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F000162 SS=E	<p>call the physician to obtain further instructions. 10. Attempts to notify the physician and their response should be documented in the resident record...."</p> <p>3.1-5(a) (2) 483.10(c)(8) LIMITATION ON CHARGES TO PERSONAL FUNDS The facility may not impose a charge against the personal funds of a resident for any item or services for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter.</p> <p>(This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)</p> <p>During the course of a covered Medicare or Medicaid stay, facilities may not charge a resident for the following categories of items and services: Nursing services as required at §483.30 of this subpart. Dietary services as required at §483.35 of this subpart. An activities program as required at §483.15(f) of this subpart. Room/bed maintenance services.</p>						

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	<p>Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.</p> <p>Medically-related social services as required at §483.15(g) of this subpart.</p> <p>Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:</p> <p>Telephone.</p> <p>Television/radio for personal use.</p> <p>Personal comfort items, including smoking materials, notions and novelties, and confections.</p> <p>Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.</p> <p>Personal clothing.</p> <p>Personal reading matter.</p> <p>Gifts purchased on behalf of a resident.</p> <p>Flowers and plants.</p> <p>Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart.</p> <p>Noncovered special care services such as</p>			

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	<p>privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by §483.35 of this subpart.</p> <p>The facility must not charge a resident (or his or her representative) for any item or service not requested by the resident. The facility must not require a resident (or his or her representative) to request any item or services as a condition of admission or continued stay. The facility must inform the resident (or his or her representative) requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents who were receiving Medicare services were informed personal hygiene items were covered under Medicare services for 3 of 3 residents reviewed for services covered by Medicare (Residents #29, #13 and #32).</p> <p>Findings include:</p> <p>1.) Resident #29's record was reviewed on 3/27/14 at 9:45 a.m. Resident #29 was admitted to the facility 2/2/14 for Medicare skilled services and continued to be covered under Medicare skilled services on 3/27/14. Resident #29's admission diagnoses included, but were not limited to, weakness, macular degeneration, hypertension and depression.</p>	F000162	<p><b>F 162</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Residents #29, #13 and #32 are offered / furnished personal toiletries items at no additional charge while receiving Medicare services.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All Medicare residents had the potential to be affected by this alleged deficient practice.</p>	04/30/2014

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	<p>Resident #29 signed and dated, 2/26/14, page 7 Admission Agreement indicated the following: "Personal Toiletries: The facility furnishes personal toiletries at a flat rate of \$15 per month. Consent (blank for check mark) Do not consent (blank for check mark)." The form had a check mark under "Do not consent."</p> <p>During a 3/27/14, 1:34 p.m. interview, Resident #29 indicated she provided her own personal hygiene items such as soap and oral care items. She indicated she believed there was a fee if she used personal care items provided by the facility.</p> <p>2.) Resident #13's record was reviewed on 3/26/14 at 9:02 a.m. Resident #13 was admitted to the facility on 2/1/14 for Medicare skilled services and continued to be covered under Medicare skilled services on 3/27/14. Resident #13's admission diagnoses included, but were not limited to, gout, constipation, insomnia and depression.</p> <p>Resident #13 signed and dated, 2/1/14, page 7 Admission Agreement indicated the following:" Personal Toiletries: The facility furnishes personal toiletries at a flat rate of \$15 per month. Consent (blank for check mark) Do not consent (blank for check mark)." The form had a check mark under "Do not consent."</p> <p>During a 3/27/14, 10:25 a.m. interview, Resident #13 indicated she or her family purchased all of her personal care items such as oral care products and deodorant. She indicated she believed there would be a fee if she used the facility provided personal</p>		<p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The company has updated the Resident Move-in Agreement and it no longer includes a cost option for hygiene items. <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for all new admits will be conducted by the ED or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of the resident Move-in Agreement to ensure the new / updated agreement that no longer includes a cost option for hygiene items is in place.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>care items. During an observation at the same time, Resident #13 had a bottle of name brand lotion on her night stand. The lotion was labeled with her name. Resident #13 indicated she had purchased the lotion.</p> <p>3.) Resident #32's record was reviewed on 3/26/14 at 10:20 a.m. Resident #32 was admitted to the facility 1/2/14 for Medicare skilled services and continued to receive skilled Medicare services on 3/27/14. Resident #32's admission diagnoses included, but were no limited to, Parkinson's disease, post bowel obstruction and macular degeneration.</p> <p>Resident #32 signed by family and dated, 1/2/14, page 7 of Resident #32's Admission Agreement indicated the following: "Personal Toiletries: The facility furnishes personal toiletries at a flat rate of \$15 per month. Consent (blank for check mark) Do not consent (blank for check mark)." The form had a check mark under "Do not consent."</p> <p>During a 3/27/14, 1:37 p.m., interview, Resident #32 indicated his family purchased all his personal hygiene items. He indicated his family had signed all his admission paperwork.</p> <p>4.) During a 3/27/14, 3:15 p.m. interview, the Admissions Coordinator/ Guest Relations Director indicated the new form for the admission process did not include information regarding the cost of hygiene items. She indicated she had used up the old forms before she started using the new forms. She indicated Resident #29, #13 and #32 had signed the old form.</p>			

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F000221 SS=D	<p>Review of the current, 11/2013, "Resident Move-in Agreement", which was provided by the Administrator on 3/27/14 at 1:00 p.m., indicated page 7 did not contain information regarding the cost of personal care items.</p> <p>3.1-6(j) 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, interview, and record review, the facility failed to evaluate residents for the least restrictive restraint or have a physician's order before applying a restraint for 2 of 3 residents reviewed for restraints. (Resident #'s 53 and 80)</p> <p>Findings include:</p> <p>1.) Resident #53 was observed in the 200 hall lounge on 3/25/14 at 9:15 a.m., restlessly moving about in her wheelchair.</p> <p>Resident #53 was observed on 3/26/14 at 7:50 a.m., in a Broda chair calling out "help me get this down."</p> <p>Resident #53 was observed on 3/26/14 at 12:05 p.m., observed sitting in the Restorative dining room in a Broda chair.</p> <p>Resident #53 was observed on 3/27/14 at 9:15 a.m. and at 1:15 p.m. She was in the 200 hall lounge sitting in her wheelchair with a lap buddy on. On each observation she</p>	F000221	<p><b>F 221</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #53 and #80 have been evaluated for the least restrictive device and a physician's order is in place.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will evaluate all residents with restraints / enablers to ensure the least restrictive device is in place along with a physician's order for its use.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or</p>	

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	<p>was requesting to have the lap buddy removed.</p> <p>Resident #53 was observed on 3/28/14 at 9:14 a.m. The resident was wheeled from the dining room to the 200 hall lounge. The resident was parked in front of the nurses station with the wheelchair brakes locked and her feet on the wheelchair foot pedals. The resident requested to have the lap buddy removed and was told it was for her protection by LPN #2. LPN #2 left the area. Resident #53 worked the lap buddy off of the wheelchair and removed her feet from the foot pedals. She had her legs straddling the foot pedals and was attempting to stand. There were no staff present.</p> <p>Resident #53's clinical record was reviewed on 3/27/14 at 10:17 a.m. The resident's diagnoses included, but were not limited to, dementia, confusion, incontinence, left hip fracture and hypertension with cardiac arrhythmia.</p> <p>The resident had a Physician's Order to discontinue occupational and physical therapy on 3/21/14 due to having met highest potential at that time. The resident received an order for occupational therapy to evaluate and treat 5 times a week for 4 weeks with treatment to include wheelchair management, therapeutic activities and patient/caregiver education. On 3/26/14, the resident received an order for a lap buddy in the wheelchair as an enabler to maintain upright position due to the resident continuing to lean forward.</p> <p>The resident had an admission Minimum Data Set Assessment dated 1/21/14. The assessment indicated the resident had</p>		<p>designee will re-educate the nursing staff on the following guideline: Restraint / Enabler Use <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review all residents with restraint / enabler to ensure there is a evaluation in place for the least restrictive device along with a physician's order for its use.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>severe cognitive impairment and was an extensive two person assist for transferring and toileting and used a wheelchair for mobility.</p> <p>Review of the Accident/Incident Reports indicated the following:</p> <p>1/25/14 at 10:00 a.m., a nurse left the resident unattended in the bathroom and the resident fell with no injury.</p> <p>3/12/14 at 7:30 a.m., the resident was found sitting on the floor with her back against the bed with no injury.</p> <p>3/16/14 at 2:40 p.m., the resident fell during a self transfer to bathroom.</p> <p>3/21/14 at 10:00 p.m., the resident slid from her bed to the floor.</p> <p>3/22/14 at 6:10 a.m., found the resident sliding off her bed.</p> <p>3/23/14 at 12:35 p.m., the resident was leaning forward in her wheelchair by the nurse's station and fell out of her wheelchair. She received a hematoma and swelling to the left cheekbone and left eyebrow. Therapy was to evaluate for wheelchair positioning.</p> <p>3/25/14 at 8:30 a.m., the resident was found sitting on the floor going through the bottom drawer of the night stand looking for personal items.</p> <p>During an interview with the Occupational Therapist on 3/26/14 at 3:45 p.m., she indicated she had evaluated Resident #53 for positioning on 3/25/14. She indicated she had recommended the Broda chair for</p>			

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	<p>positioning for the resident. She indicated the resident was able to propel a wheelchair and could not propel the Broda chair. She indicated the Nursing department would not let her recommend a lap buddy because it was considered to be a restraint. She indicated nursing did not consider a Broda chair to be a restraint. She indicated the lap buddy was less restrictive for the resident than the Broda chair. The lap buddy was applied.</p> <p>During an interview with the Occupational Therapist on 3/28/14 at 10:05 a.m., she indicated she had removed the pedals from Resident #53's wheelchair on 3/27/14 due to the resident trying to stand and it was a safety risk. She indicated she had informed nursing not to use them.</p> <p>2. During an observation, dated 3/26/14 at 3:37 p.m., Resident #80 was transferred from the broda chair to the bed using a mechanical lift. The resident was observed in the supine position resting quietly. Both full padded siderails were in the up position.</p> <p>During an observation on 3/27/14 at 10:31 a.m., Resident #80 was observed receiving incontinent care from 2 Certified Nursing Assistants (CNA). Resident #80 was verbally cued to grab the siderail near his head to assist with repositioning. The resident was able to use the upper part of the padded side rails to assist with turning. The resident did not slide down in the bed nor use the lower half of the siderails. Both full padded siderails were in the up position.</p>				

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	<p>During the chart review on 3/25/2014 at 3:13 p.m., the diagnoses for Resident #80 included, but were not limited to, fracture of right hip, senile dementia, hyperlipidemia, diverticulosis of colon, hypothyroidism, osteoporosis, unspecified essential hypertension, chronic pain, vitamin D deficiency.</p> <p>Current orders included, but were not limited to, bed alarm on at all times to alert staff of transfers, dated 6/19/13. Change alarm batteries the 15th of every month, alarm expires 4/16/14, dated 6/19/13. Bed to be in lowest position with floor mats to avoid injury from fall out of bed, dated 1/12/14. Siderails up times 1/4 as enabler, dated 6/19/13. Hospice dated 6/20/13.</p> <p>The falls care plan, dated 3/18/14, indicated "I am at increased risks for falls due to my decreased mobility. I am at risk for injury related to falls and would like staff to ensure that I have alarms in place and functioning so that staff can be made aware of unassisted transfers. I would like my bed to be in the lowest position and bedside mats on the floor beside my bed. I would like for the staff to observe for fall risk behaviors (increased confusion, urinary urgency..). I would like my pathways kept free of clutter. I want my call light left within reach in my room so that I may call for assistance as I need it."</p> <p>The care plan for Activities of Daily Living (ADL's), dated 3/18/14, indicated "... I want the nursing staff of allow me to be as independent as possible. I need a specialty mattress in place due to me sliding down in bed...."</p> <p>The "Nursing Admission Assessment and</p>			

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	<p>Data Collection", dated 6/18/13, indicated Resident #80 used 2 quarter length siderails for bed mobility.</p> <p>The "Assessment Review and Considerations", dated 6/18/13, indicated Resident #80 was at risk for falls due to cognitive impairment, mobility impairment. "Although risk factors have been identified they do not currently present a risk to the resident. Care givers will continue to monitor for impact and care plan as appropriate. Restraint/enabler use: This resident does not require/request the use of a restraint or enabler."</p> <p>The "Monthly Nursing Assessment and Data Collection", dated 1/14/14, indicated Resident #80 used 2 full siderails for bed mobility and low bed with floor mat. No documentation was presented under Fall Risk.</p> <p>The "Monthly Nursing Assessment and Data Collection", dated 3/1/14, indicated Resident #80 used 2 full siderails for bed mobility. "An individualized care plan has been initiated to minimize the risk of falling and/or reduce the likelihood of injury."</p> <p>A "Fall Report", dated 12/15/13, indicated "Staff stated res wiggles in bed at times. Res found on floor by staff. Staff noticed alarm broken the clip to plug into alarm had broken off. Alarm was replaced and staff educated to keep bed in lowest position."</p> <p>The "Clinically At Risk Individual Monitoring Sheet", dated 12/19/13, indicated the resident fell from the bed and the alarm did not function properly. The recommended clinical interventions included bed in low position and replace the bed alarm.</p>						

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	<p>During an interview with the Director of Nursing (DoN) on 3/26/14 at 3:23 p.m., the DoN indicated Resident #80 was in a hospice bed and that all hospice beds had full siderails. The resident also had a "scoop" mattress on his bed to prevent him from sliding down in bed. During a check of all hospice beds on the 100 hall, including Resident #80, 6 beds were checked and only one bed observed with full siderails.</p> <p>In response to a request for information on 3/27/14 at 11:38 a.m., the DoN provided information indicating the full siderails were placed on Resident #80's bed on 7/24/13 per hospice for comfort and safety. The DoN indicated there was no physician order for the full siderails. The DoN also indicated the resident had no falls prior to 7/24/13.</p> <p>During an interview on 3/28/14 at 2:17 p.m., Hospice Nurse #12 indicated the full siderails were placed on the bed to Resident #80 at the request of the facility because the resident was "sliding and falling" out of bed. She indicated that whenever the facility requests equipment, it has been the practice of the hospice company to provide the equipment. "We go by whatever they ask of us because they are with the patients more."</p> <p>3. An undated policy entitled "Guidelines for Restraint/Enabler Use" was provided by the DoN on 3/27/14 at 3:50 p.m.</p> <p>"Purpose: To ensure completion of assessment and evaluation for appropriate and safe use of restraints.</p> <p>Procedure:</p>			

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	<p>1. Each resident shall have an individualized nursing assessment upon admission, monthly and PRN that shall address the need for a safety device, medical reason for use of the device and identification of rather the device restricts movement, or limits the resident from doing [sic] something they could previously do....</p> <p>...a. Evaluate all factors leading to consideration of a device....</p> <p>...c. Investigate alternatives to restraints and determine that all alternative measures have been exhausted and found to be unsuccessful....</p> <p>... 6. The determination of whether a device is or is not a restraint is based on an individualized, assessment of the resident. The assessment identifies the specific medical symptom and evaluates the risk and benefits and the purpose being considered for the use of a device or practice. The determination must include whether the resident is capable of independently removing the device and whether the device restricts the resident's freedom of movement. The answers to these questions will vary with the individual resident situation.</p> <p>7. Assess the resident to determine functional status. Consideration should be taken to determine what the level of function is, what is important to the resident to maintain and what quality of life area will the use of the device improve, maintain or enhance. Improved functional status can be physical or emotional.</p> <p>8. Considerations for determining whether the device is a restraint or an enabler:...</p> <p>...c. If a device restricts the resident from doing something they could previously do and does NOT assist the resident to function at a higher level, it is a restraint and may be</p>			

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F000241 SS=E	<p>used for a limited timeframe...."</p> <p>3.1-3(w) 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure dependent residents were served meals in a dignified manner regarding lengthy waits for meal service, serving and assisting a visually impaired resident from his blind side and not offering dependent residents the same food items that were offered to independent residents for 2 of 2 meals observed (3/24/14 lunch and 3/26/14 lunch). This deficient practice impacted 8 of 8 dependent residents reviewed for dignified dining (Resident #94, #68, #18, #22, #80, #3, #54 and #36).</p> <p>Findings include:</p> <p>1.) Resident #18's record was reviewed on 3/27/14 at 4:50 p.m. Resident #18's current diagnoses included, but were not limited to, malignant neoplasm of brain and spinal cord with blindness, extreme and weakness. Resident #18 had a current, 3/14, physician's order for a mechanical soft diet.</p> <p>A current, 3/17/14, quarterly, Minimum Data Set (MDS) assessment indicated Resident #18 required cueing and assistance for decision making, understood others and was understood by others, used a wheelchair,</p>	F000241	<b>F 241</b>  <b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Residents #94, #68, #18, #22, #80, #3, #54, and #36 were observed at 3 meal to ensure the following: residents are served in a dignified manner to ensure there are not lengthy waits for meal service, staff are not serving / assisting residents from their visually impaired side and residents are offered the same food items that were offered to independent residents. In addition, observed to ensure residents do not manipulate the table settings such as table cloths, silverware, drinking glasses. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will observe 3 meals at to ensure the following:				

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	<p>required extensive for mobility and required extensive assistance of one person for eating.</p> <p>During a 3/24/14, lunch meal observation, Resident #18 was seated at a dining room table as if ready to dine. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #18 sat facing the table with no form of stimulation from 12:05 p.m. until 12:31 p.m. when her meal was served (a total of 26 minutes).</p> <p>During a 3/26/14, lunch meal observation, Resident #18 was escorted into the room by a staff member and was seated at a dining room table as if ready to dine at 12:03 p.m. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #80 sat facing the table with no form of stimulation from 12:03 p.m. until 12:33 p.m. when her meal was served (a total of 30 minutes).</p> <p>2.) Resident #3 record was reviewed on 3/27/14 at 9:15 a.m. Resident #3's current diagnoses included but were not limited to, hypertension, dementia and anxiety. Resident #3 had a current 3/14 order for a regular diet.</p> <p>A current, 1/24/14, admission Minimum Data Set (MDS) assessment indicated Resident #3 rarely or never made choices, usually understood others and was understood by others, used a wheelchair, required extensive assistance from staff for mobility and required extensive assistance from one staff member to eat.</p> <p>During a 3/24/14, lunch meal observation,</p>		<p>residents are served in a dignified manner to ensure there are not lengthy waits for meal service, staff are not serving / assisting residents from their visually impaired side and residents are offered the same food items that were offered to independent residents.</p> <p>In addition, observe to ensure residents do not manipulate the table settings such as table cloths, silverware, drinking glasses.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> The time for Restorative Dining Room meal service has been changed so the residents requiring assist with feeding are served first.</p> <p>A staff member will be assigned to the Restorative Dining Room upon residents arrival to provide pre-meal diversionary interaction. The staff member will also monitor to ensure residents do not manipulate the table settings such as table cloths, silverware, drinking glasses. If any items are manipulated by a resident, they will be replaced. The nursing staff will be educated on this.</p> <p>DHS or designee will re-educate the nursing staff on the following expectations in regards to serving residents in a dignified manner:</p> <p>1). Timely meal service / food</p>				

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	<p>Resident #3 was seated at a dining room table as if ready to dine. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #3 sat facing the table with no form of stimulation from 12:05 p.m. until 12:31 p.m. when his meal was served (a total of 26 minutes).</p> <p>During a 3/26/14, lunch meal observation, Resident #3 was escorted into the room by a staff member and was seated at a dining room table as if ready to dine at 11:59 a.m. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #80 sat facing the table with no form of stimulation from 11:59 a.m. until 12:30 p.m. when his meal was served (a total of 31 minutes).</p> <p>3.) Resident #36's record was reviewed on 3/27/14 at 4:55 p.m. Resident #36's current diagnoses included, but were not limited to, advanced dementia and hypertension. Resident #36 had a current, 3/14, order for a pureed diet.</p> <p>A current, 12/21/13, quarterly Minimum Data Set (MDS) assessment indicated Resident #36 rarely or never understood others, used a wheelchair, required extensive assistance from staff for mobility and required extensive assistance from one staff to eat.</p> <p>During a 3/24/14, lunch meal observation, Resident #36 was seated at a dining room table as if ready to dine. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #36 sat facing the table with no form of stimulation from 12:10 p.m. until 12:28 p.m. when her meal was served (a</p>		<p>and drinks placed within resident's reach / prompt assistance with eating 2). Replacing of table settings such as table cloths, silverware, drinking glasses if any items are manipulated by residents. 3). Serving / assisting residents that are visually impaired from their un-impaired side 4). Residents in the Restorative Dining Room are to be offered the same food items that are offered to independent residents in the main dining room</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following observations of meal service in the Restorative Dining Room will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>1). Timely meal service / food and drinks placed within resident's reach / prompt assistance with eating 2). Replacing of table settings such as table cloths, silverware, drinking glasses if any items are manipulated by residents. 3). Serving / assisting residents that are visually impaired from their un-impaired side 4). Residents in the Restorative Dining Room are to be offered the same food items that are offered to independent residents in the main dining room 5). Adherence to the time change for Restorative</p>				

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	<p>total of 18 minutes). At 12:28 p.m., dependent Resident #36's meal tray was placed in front of her. No one assisted Resident #36 to eat her meal until 12:44 p.m. Her meal tray sat uncovered, on the table in front of her for 16 minutes before she was offered assistance.</p> <p>During a 3/26/14, lunch meal observation, Resident #36 was escorted into the room by a staff member and was seated at a dining room table as if ready to dine at 12:12 p.m. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #36 sat facing the table with no form of stimulation from 12:12 p.m. until 12:33 p.m. when his meal was served (a total of 21 minutes).</p> <p>4.) Resident #94's record was reviewed on 3/27/14 at 4:40 p.m. Resident #94's current diagnoses included, but were not limited to, glaucoma, depression and dementia. Resident #94 had a current, 3/14, order for a regular finger food diet.</p> <p>A current, 2/3/14, quarterly, Minimum Data Set (MDS) assessment indicated Resident #94 rarely or never made decisions, sometimes understood others, used a wheelchair, required extensive assistance from staff for mobility and required extensive assistance from one staff member to eat.</p> <p>During a 3/24/14, lunch meal observation, Resident #94 was seated at a dining room table as if ready to dine. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #94 sat facing the table with no form of stimulation from 12:05 p.m. until 12:29 p.m. when her meal was served (a</p>		<p>Dining Room meal service to ensure the residents requiring assistance with feeding are served first. 6). A staff member is assigned to the Restorative Dining Room upon resident's arrival and the staff member provides pre-meal diversionary interaction.</p> <p>Throughout the audit / observation period, all 3 meal services will be observed.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>total of 24 minutes).</p> <p>During a 3/26/14, lunch meal observation, Resident #94 was escorted into the room by a staff member and was seated at a dining room table as if ready to dine at 11:55 a.m. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #94 sat facing the table with no form of stimulation from 11:55 a.m. until 12:33 p.m. when her meal was served (a total of 38 minutes).</p> <p>5.) Resident #54's record was reviewed on 3/28/14 at 11:00 a.m. Resident #54's current diagnoses included, but were not limited to, Parkinson's disease, debility, and dementia. Resident #54 had a current, 3/14, order for a mechanical soft diet with nectar thickened liquids.</p> <p>Resident #54 had a current, 2/17/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident rarely made decisions, usually understood others, used a wheelchair, was dependent on staff assistance for mobility, received a mechanically altered diet and required extensive assistance from one staff to eat.</p> <p>Resident #54 had a 4/30/13, most current, Speech Therapy note which indicated "Patient was referred due to decline in oropharyngeal swallow....Diet was changed to mechanical soft with nectar thick liquids. Patient demonstrated inconsistent cough with thin liquids."</p> <p>During a 3/24/14, lunch meal observation, Resident #54 was seated at a dining room table as if ready to dine. The Restorative Dining Room lacked any form of</p>						

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	<p>entertainment or diversionary materials. Resident #54 sat facing the table with no form of stimulation from 12:05 p.m. until 12:30 p.m. when her meal was served (a total of 25 minutes).</p> <p>During a 3/26/14, lunch meal observation, Resident #54 was escorted into the room by a staff member and was seated at a dining room table as if ready to dine at 12:08 p.m. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #54 sat facing the table with no form of stimulation from 12:08 p.m. until 12:33 p.m. when her meal was served (a total of 25 minutes).</p> <p>6.) Resident #68's record was reviewed on 3/26/14 at 8:40 a.m. Resident #68's current diagnoses included, but was not limited to, Alzheimer's disease. Resident #68 had a current, 3/14, order for a pureed diet.</p> <p>Resident #68 had a current, 12/17/13, quarterly, Minimum Data Set (MDS) assessment which indicated the resident rarely or never made decisions, used a wheelchair, required staff assistance for mobility and required extensive assistance from one staff member for eating.</p> <p>During a 3/24/14, lunch meal observation, Resident #68 was seated at a dining room table as if ready to dine. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #68 sat facing the table with no form of stimulation from 12:11 p.m. until 12:30 p.m. when his meal was served (a total of 19 minutes). During this 19 minutes, Resident #68 removed the table cloth and tossed it to the center of the table. Tossed</p>			

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NAME OF PROVIDER OR SUPPLIER  MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
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	<p>his silverware and his table mates' silverware on top of the rumpled table cloth. Then he manipulated and tossed the table cloth about on and off for the complete 19 minute period.</p> <p>During a 3/26/14, lunch meal observation, Resident #68 was escorted into the room by a staff member and was seated at a dining room table as if ready to dine at 12:12 p.m. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #68 sat facing the table with no form of stimulation from 12:12 p.m. until 12:33 p.m. when his meal was served (a total of 21 minutes).</p> <p>During a 3/24/14, 12:30 p.m. Restorative Dining lunch observation, CNA #5 straightened the table cloth Resident #68 had tossed to the center of the table and manipulated during the time he waited and placed the same handled table cloth on the table were Residents #22, #94 and #68 were dining. CNA #5 then gave the silverware which was closest to each resident to that resident. Resident #68 had handled the silverware which was given to Resident #94.</p> <p>During a 3/24/14, 12:33 p.m., lunch observation, Resident #22's glass of thickened liquid was placed on the table out of his line of sight. At 12:37 p.m. Resident #68 grabbed Resident #22's glass putting his fingers inside the cup. Resident #68 moved the glass and placed it in front of Resident #94.</p> <p>During a 3/24/14, 12:40 p.m., observation, CNA #7 took the glass of thickened liquids Resident #68 had placed his hand in and served it to Resident #22.</p>			

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	<p>During a 3/24/14, 12:45 p.m., interview, CNA #7 indicated she did not consider how Resident #22's glass had gotten to the other side of the table. She just knew the glass with thickened liquids was his so she gave it to him.</p> <p>During a 3/24/14, 12:43 p.m., interview, CNA #5 indicated she should have gotten a clean tablecloth and clean silverware for Residents #22, #94 and #68. She indicated she had not considered they had been touched by a resident.</p> <p>7.) Resident #80's record was reviewed on 3/25/14 at 3:13 p.m. Resident #80's current diagnoses included, but were not limited to, chronic pain and senile dementia. Resident #80 had a current, 3/14, order for a mechanical soft diet.</p> <p>A current, 12/15/13, quarterly, Minimum Data Set (MDS) assessment indicated Resident #80 rarely made decisions, used a wheelchair, required staff extensive assistance for mobility and required extensive assistance of one staff for eating.</p> <p>Resident #80 had a current 1/9/14 Nutrition Progress Note which indicated the resident had a 15% weight loss over a 6 month period.</p> <p>Resident #80 had a current 12/10/13 care plan problem regarding nutritional needs. Approaches to this problem included, but were not limited to, "assist me at meals as needed so that I may safely and as independently as possible consume any food and beverages served.</p> <p>During a 3/24/14, lunch meal observation,</p>						

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	<p>Resident #80 was seated at a dining room table as if ready to dine. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #80 sat facing the table with no form of stimulation from 12:05 p.m. until 12:30 p.m. when his meal was served (a total of 25 minutes).</p> <p>During a 3/26/14, lunch meal observation, Resident #80 was escorted into the room by a staff member and was seated at a dining room table as if ready to dine at 11:50 a.m. The Restorative Dining Room lacked any form of entertainment or diversionary materials. Resident #80 sat facing the table with no form of stimulation from 11:50 a.m. until 12:33 p.m. when his meal was served (a total of 43 minutes).</p> <p>During a 3/26/14, 12:33 p.m., lunch observation, Resident #80 was seated at the dining room table in a broda chair. His plate was in front of him on the table. The plate was approximately 3 inches from the edge of the table. When seated with his back against the back of the chair, Resident #80 could not reach all the items on his plate. He used his knife and drug a dinner roll within reach. he ate the dinner roll. He used his knife and stretched and reached casserole from the far side of his plate. He ate the casserole off his knife. Resident #80 could successfully reach about 1/3 of his plate. He ate all the food located on that 1/3 section of his plate. At no time did any staff member assist Resident #80 to reach his plate or obtain the food items which were out of reach. At 12:50 p.m., CNA #9 was requested to turn Resident #80's plate and move it within reach. (17 minutes after the meal was served). After the meal was positioned within reach,</p>			

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	<p>Resident #80 was able to eat 75% of his meal.</p> <p>8.) Resident #22's record was reviewed on 3/25/14 at 3:15 p.m. Resident #22's current diagnoses included but was not limited to, right orbital cancer, legally blind, Parkinson's disease and dementia. Resident #22 had a current 3/14 order for a pureed diet with honey thickened liquids.</p> <p>During a 3/26/14, 12:40 p.m. meal observation, CNA #9 sat down beside Resident #22 who was having some difficulty drinking his thickened liquids. Resident #22 had a patch covering his right eye. CNA #9 sat on Resident #22's right side out of his line of sight. She reached across him to offer assistance not being visible to Resident #22 until her hand passed the area that was obscured by the bandage. CNA #9 offered all assistance she provided to Resident #22 from his right side where his eye was bandaged.</p> <p>During a 3/28/14, 9:10 a.m. interview, the MDS Coordinator indicated the care plans do not have individualized approached or information, such as the resident can drink fluids from a cup if handed to her but she needs fed her meal. The care plans expect the staff to watch the residents each meal and observe what they need. Staff should see the bandage on Resident #22's eye and be aware they should serve him and assist him from the side without a patch.</p> <p>9.) During a 3/24/14, 12:05 p.m. to 1:00 p.m., lunch observation in the Restorative Dining Room, no soup was offered to any resident dining in the restorative dining room. At the same time, soup was offered to all</p>			

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F000257 SS=D	<p>residents dining in the main dining room.</p> <p>During a 3/26/14, 11:50 a.m. to 12:40 p.m., lunch observation in the Restorative Dining Room, no soup was offered to any resident dining in the restorative dining room. At the same time, soup was offered to all residents dining in the main dining room.</p> <p>During a 3/26/14, 12:57 p.m., interview, CNA #5 indicated she did not offer soup in the Restorative Dining Room because she was so busy she could not think of everything.</p> <p>During a 3/26/14, 1:00 p.m., interview, CNA #9 indicated the CNAs were supposed to offer the residents in the Restorative Dining Room the same as in the Main Dining Room.</p> <p>During a 3/27/14, 1:55 p.m., interview, the Food Services Supervisor indicated most every soup could be offered to regular and mechanical soft diets but not all, about 98% could be served to both. Pureed soup was made upon request. It was not good that residents in the Restorative Dining Room were not offered soup either Monday or Wednesday at lunch. The facility practice was to offer all residents soup.</p> <p>3.1-3(t) 483.15(h)(6) COMFORTABLE &amp; SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>Based on observation and interview, the facility failed to ensure resident bathrooms</p>	F000257	F 257  Corrective actions accomplished for those				

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	<p>were warm and comfortable for 2 of 17 residents interviewed. (Resident #25 and #115)</p> <p>Findings include:</p> <p>1. During an interview on 3/24/14 at 2:27 p.m., Resident #25 indicated her bathroom had no heat and would get cold if the bathroom door was closed. She indicated the staff would forget to leave the bathroom open and the bathroom would get cold. She indicated there was a vent in the wall to help keep the water pipes from freezing. An observation of the bathroom was made during the interview and there was a vent in the wall below the sink.</p> <p>2. During an interview with Resident #115 on 3/25/14 at 10:16 a.m., he said "I keep my bathroom door open because the bathroom is cold."</p> <p>3. During an interview with the Director of Plant Operations on 3/25/14 at 4:03 p.m., he indicated there was no heat in any of bathrooms in the resident rooms. He indicated there were signs posted at the nurse's stations to keep the residents' bathroom doors open to keep the pipes from freezing.</p> <p>On 3/26/14 at 8:49 a.m., a sign at the 200 hall nurse station indicated "REMINDER TO EVERYONE During the winter months it is important that we leave the bathroom doors open or cracked to allow heat in the bathroom to avoid pipes from freezing. Thank You [Name of Staff] Director of Plant Operations"</p> <p>During an interview with the Administrator on</p>		<p><b>residents found to be affected by the alleged deficient practice:</b> Resident #115 has been discharged. Resident #25 - a heating device has been installed in the residents room.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> ED or designee will interview residents and ask if there are any concerns with the temperature that may affect their comfort level. If resident voices a concern, installation of a hearing device will be offered.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> 1). ED or designee will re-educate the staff regarding leaving the bathroom doors open to promote warm air circulation.</p> <p>2). The following interviews for 5 residents/family members per hallway will be conducted by the ED or designee 1 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents will be asked if there are any concerns with the temperature that may affect their comfort level. If resident voices a concern, installation of a heating device will be offered.</p>				

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F000279 SS=D	<p>3/28/14 at 3:05 p.m., he indicated the water in two or three bathrooms had frozen during the really cold weather.</p> <p>During an interview with the Director of Plant Operations on 3/31/14 at 10:50 a.m., he indicated he had cut holes in the bathroom walls by the water pipes and covered them with a vent to keep the pipes warm after they were thawed.</p> <p>3.1-19(j)</p> <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</p>		<p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following interviews for 5 residents/family members per hallway will be conducted by the ED or designee 1 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents will be asked if there are any concerns with the temperature that may affect their comfort level. If resident voices a concern, installation of a heating device will be offered.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plan interventions were based on individual needs for 1 of 1 resident reviewed for dialysis. (Resident #89)</p> <p>Findings include:</p> <p>Resident #89's clinical record was reviewed on 3/26/14 at 9:25 a.m. The resident's diagnoses included, but were not limited to, chronic renal failure, severe debility, chronic pain and end stage renal disease.</p> <p>The record indicated the resident had a fistula in his right arm and went out for dialysis on Mondays, Wednesdays and Fridays.</p> <p>The "Skilled Nursing Assessment and Data Collection" indicated the resident's fistula had no bruit or thrill on February 24, March 6, 7, 21, or 25, 2014.</p> <p>Review of the "Skilled Nursing Assessment and Data Collection", Nurse's Notes, and Medication Administration Records [MARs] lacked documentation of daily assessments of the fistula's bruit and thrill for February 22, 27, 28, March 8, 9, 13, and 14, 2014. The care plan does not address assessing for a bruit and thrill.</p>	F000279	<p><b>F 279</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #89 - care plan interventions were updated based on individual needs related to dialysis. In addition, the resident's medical record was reviewed to ensure there was daily assessment of the bruit and thrill documented.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all residents receiving dialysis services to ensure the interventions are based on individual needs related to dialysis. In addition, the resident's medical record was reviewed to ensure there was dialy assessment of the bruit and thrill documented.</p>	04/30/2014

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	<p>The resident had a, 3/18/14, care plan problem of Renal disease. The care plan indicated the resident would like the staff to monitor his dialysis site. The intervention failed to include how often the site should be monitored.</p> <p>During an interview on 3/26/14 at 10:45 a.m., LPN #1 indicated the fistula's bruit and thrill was checked every shift and documented in the MAR. She reviewed the March, 2014 MAR and could not find where it was documented.</p> <p>During an interview on 3/27/14 at 10:35 a.m., Medical Records LPN indicated the doctor should be notified if there was no bruit or thrill. She indicated the site should be checked for bleeding when the resident returns from dialysis.</p> <p>During an interview with the Director of Nursing on 3/27/14 at 12:40 p.m., she indicated there were no daily assessments of the bruit and thrill for February 22, 27, 28, March 8, 9, 13, and 14, 2014.</p> <p>The January, 2014, "Guidelines For Monitoring Shunt: Hemodialysis Arteriovascular Access (AV) (Fistula, Graft or Central Venous Catheter)" procedure was provided by the Director of Nursing on 3/26/14 at 12:45 p.m. The procedure indicated the fistula should be monitored daily and the attending physician, dialysis center and responsible party should be notified of adverse findings.</p> <p>3.1-35(d)(2)</p>		<p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Interdisciplinary Team on the following campus guidelines: 1). Care Plans 2). Monitoring Shunt: Hemodialysis Arteriovascular Access (AV) (Fistula, Graft or Central Venous Catheter)</p> <p>DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1). Monitoring Shunt: Hemodialysis Arteriovascular Access (AV) (Fistula, Graft or Central Venous Catheter)</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review all residents per receiving dialysis services to ensure the interventions are based on individual needs related to dialysis. In addition, the resident's medical record will be reviewed to ensure there is a dialy assessment of the bruit and thrill documented.</p>		

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F000280 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 ensure a health care plan related to fluid restriction and bowel monitoring was reviewed and updated for 1 of 30 residents reviewed for comprehensive health care plans. (Resident #28)</p> <p>Findings include:</p> <p>The clinical record for Resident #28 was</p>	F000280	<p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p><b>F 280</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #28 care plan was reviewed and updated related to fluid restriction and bowel monitoring problem / goals / interventions.</p>	

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	<p>reviewed on 3/25/14 at 3:09 p.m. Diagnoses for Resident #28 included, but were not limited to, hypertension, congestive heart failure, and partial colon obstruction.</p> <p>A health care plan problem, developed 3/11/14, indicated the resident was at risk for nutritional impairments. One of the goals for this problem was to be free of signs and symptoms of fluid imbalance. Approaches for this problem included, but were not limited to, monitor for complaints of hunger or thirst, and offer and encourage fluid intake as necessary.</p> <p>Current physician's orders, signed 2/12/14, for Resident #28 included, but were not limited to, the following order:</p> <p>a.) 2000 milliliter (ml) fluid restriction: 360 ml with each meal, 200 ml per nursing with medications. The original date of this order was 1/22/14.</p> <p>The health care plan problem, noted as reviewed 3/11/14, lacked any information related to the resident's ordered fluid restriction.</p> <p>A health care problem, developed 2/5/14, indicated the resident recently had a bowel obstruction which lead to surgery and was occasionally incontinent of bowel and bladder. The care plan lacked any goals in regards to bowel movements or prevention of constipation.</p> <p>During an interview with the Assistant Director of Nursing, on 3/28/14 at 2:57 p.m., additional information related to the care plan was requested for Resident #28.</p>		<p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review and update all care plans related to fluid restriction and bowel monitoring problems / goals / interventions.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Interdisciplinary Care Plan Team on the following guideline: Interdisciplinary Team Care Plan</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of care plans for fluid restriction and bowel monitoring to ensure problems / goals / interventions are in place.</p> <p>The results of the audit observations will be reported, reviewed and trended for</p>		

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F000282 SS=D	<p>During an interview with the MDS (Minimum Data Set Assessment) Coordinator, on 3/28/14 at 3:19 p.m., she indicated the care plan for Resident #28 had lacked information related to the fluid restriction and bowel monitoring.</p> <p>Review of the current facility policy, dated 1/08, titled "INTERDISCIPLINARY TEAM CARE PLAN GUIDELINE," provided by the DoN on 3/28/14 at 8:00 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of condition impairment, disability or disease in accordance with state and federal guidelines.</p> <p>PROCEDURE:...</p> <p>...e. The "Change in Condition" form may be utilized to reflect changes, additions, or discontinuation of care plan interventions to a specific problem area or to reveal a new problem area...."</p> <p>3.1-35(d)(2)(B) 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure laboratory tests were obtained timely as ordered by the physician for 1 of 5 residents reviewed for laboratory testing related to medication use. (Resident</p>	F000282	<p>compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p><b>F 282 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #46 has been discharged. <b>Identification of other residents having the</b></p>	

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	<p>#46)</p> <p>Findings include:</p> <p>The clinical record for Resident #46 was reviewed on 3/26/14 at 10:15 a.m. Diagnoses for Resident #46 included, but were not limited to, hypertension, depression, congestive heart failure, humerus fracture, and chronic renal disease.</p> <p>The clinical record indicated Resident #46 was to have a Comprehensive Metabolic Panel (CMP) and Complete Blood Count (CBC) every 2 weeks. The original date for the laboratory tests were 12/23/13.</p> <p>The clinical record contained a CMP and CBC completed on 1/6/14, 2/6/14, and 3/4/14.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 3/28/14 at 9:46 a.m., additional information was requested related to the missing physician ordered CMPs and CBCs.</p> <p>During an interview with ADoN, on 3/28/14 at 12:54 p.m., she indicated she had no further information to provide related to the physician order laboratory tests.</p> <p>Review of the current facility policy, dated 11/22/08, titled "LAB TRACKING GUIDELINES," provided by the DoN on 3/28/14 at 8:00 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To facilitate a method of tracking laboratory tests ordered and monitor test has been completed in a timely manner to identify and treat infections and/or make</p>		<p><b>potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will review all resident lab orders for past 14 days to ensure the lab tests were obtained in a timely manner as ordered by the MD. <b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Lab Tracking <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review of medical record to ensure the lab test were obtained in a timely manner as ordered by the MD. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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F000309 SS=E	<p>medication adjustments.</p> <p>PROCEDURE:...</p> <p>...2. The nursing staff or person designated by the Executive Director or Director of Health Services shall monitor the "Tracking Log" to ensure tests have been completed per the physician order....</p> <p>3.1-35(g)(2) 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure daily monitoring of a fistula was completed for 1 of 1 resident reviewed for dialysis (Resident #89), failed to check for a residual urine in a timely manner for 1 of 3 residents reviewed for accidents (Resident #53), failed to ensure bowel monitoring was completed so interventions to relieve constipation could be given for 1 of 5 residents reviewed for unnecessary medications (Resident #28) and failed to ensure hospice nurse visits were completed as contracted for 3 of 4 residents reviewed for hospice services. (Resident #79, #18, and #36)</p> <p>Findings include:</p> <p>1.) Resident #89's clinical record was reviewed on 3/26/14 at 9:25 a.m. The</p>	F000309	<p><b>F 309</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #89 - the resident's medical record was reviewed to ensure there was daily assessment of the bruit and thrill documented. Resident #53 - residual urine was obtained and MD notified of results. Resident #28 - bowel monitoring protocol in place to prevent constipation. Residents #79, #18 and #36 - Hospice Nurse visits completed as contracted.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged</b></p>	
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	<p>resident's diagnoses included, but were not limited to, chronic renal failure, severe debility, chronic pain and end stage renal disease.</p> <p>The record indicated the resident had a fistula in his right arm and went out for dialysis on Mondays, Wednesdays and Fridays.</p> <p>The "Skilled Nursing Assessment and Data Collection" indicated the resident's fistula had no bruit or thrill on February 24, March 6, 7, 21, or 25, 2014.</p> <p>Review of the "Skilled Nursing Assessment and Data Collection", Nurse's Notes, Medication Administration Records [MARs] for February and March 2014, lacked documentation of daily assessments of the fistula's bruit and thrill for February 22, 27, 28, March 8, 9, 13, and 14, 2014.</p> <p>The resident had a, 3/18/14, care plan problem of Renal disease. The care plan indicated the resident would like the staff to monitor his dialysis site.</p> <p>During an interview on 3/26/14 at 10:45 a.m., LPN #1 indicated the fistula's bruit and thrill was checked every shift and documented in the MAR. She reviewed the March, 2014 MAR and could not find where it was documented.</p> <p>During an interview on 3/27/14 at 10:35 a.m., Medical Records LPN indicated the doctor should be notified if there was no bruit or thrill. She indicated the site should be checked for bleeding when the resident returned from dialysis.</p>		<p><b>deficient practice and corrective actions taken:</b> The DHS or designee will complete the following: 1). Review the medical record of all residents receiving dialysis services to ensure there is daily assessment of the bruit and thrill documented. 2). Review all resident lab orders for past 30 days to ensure the lab tests were obtained in a timely manner as ordered by the MD. 3). Ongoing review during daily clinical meeting (5 times per week) of all residents with no bowel movement in 48 and 72 hours to ensure bowel monitoring and bowel protocol orders are being followed to prevent constipation. 4). Review of all residents receiving hospice services to ensure Nurse visits are completed as contracted.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1). Monitoring Shunt: Hemodialysis Arteriovascular Access (AV) (Fistula, Graft or Central Venous Catheter) 2). Lab Tracking 3). Bowel Protocol 4). Hospice Services / Nurse visit documentation as contracted</p> <p><b>How the corrective measures</b></p>		

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	<p>During an interview with the Director of Nursing on 3/27/14 at 12:40 p.m., she indicated there were no daily assessments of the bruit and thrill for February 22, 27, 28, March 8, 9, 13, and 14, 2014.</p> <p>The January, 2014, "Guidelines For Monitoring Shunt: Hemodialysis Arteriovascular Access (AV) (Fistula, Graft or Central Venous Catheter)" procedure was provided by the Director of Nursing on 3/26/14 at 12:45 p.m. The procedure indicated the fistula should have been monitored daily and the attending physician, dialysis center and responsible party should have been notified of adverse findings.</p> <p>2.) Resident #53's clinical record was reviewed on 3/27/14 at 10:17 a.m. The resident's diagnoses included, but were not limited to, dementia, confusion, incontinence, and hypertension with cardiac arrhythmia.</p> <p>The resident had a, 3/21/14, physician's order for an in and out catheter for a post void residual, may send for urine analysis and culture and sensitivity.</p> <p>The resident had a, 3/29/14, physician's order for Macrobid (an antibiotic) 100 mg one tablet by mouth twice a day for one week for a urinary tract infection.</p> <p>Review of a, 3/21/14, Nurse Practitioner's note indicated the post void residual was for urine frequency.</p> <p>The resident had an admission Minimum Data Set Assessment dated 1/21/14. The assessment indicated the resident had severe cognitive impairment and was an extensive two person assist for transferring</p>		<p><b>will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>1). Review the medical record of all residents receiving dialysis services to ensure there is daily assessment of the bruit and thrill documented. 2). Review resident lab orders to ensure the lab tests were obtained in a timely manner as ordered by the MD. 3). Ongoing review during daily clinical meeting (5 times per week) of all residents with no bowel movement in 48 and 72 hours to ensure bowel monitoring and bowel protocol orders are being followed to prevent constipation. 4). Review of all residents receiving hospice services to ensure Nurse visits are completed as contracted.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>and toileting.</p> <p>Review of the March, 2014, Medication Record indicated the post residual urine void was not completed until 3/26/14 and the results were 300 mls recorded on 3/27/14. This resulted in a five day delay before the post void residual urine check was completed.</p> <p>During an interview with the Director of Nursing on 3/28/13 at 10:54 a.m., she indicated the post void residual urine had been done by the third shift nurse. She indicated she did not think the nurse knew what a residual urine was. She indicated she did not know why the residual urine had not been checked sooner.</p> <p>3.) The clinical record for Resident #28 was reviewed on 3/25/14 at 3:09 p.m. Diagnoses for Resident #28 included, but were not limited to, hypertension, congestive heart failure, and partial colon obstruction.</p> <p>A significant change Minimum Data Set (MDS) assessment, dated 1/28/14, indicated Resident #28 required the extensive assistance of 2 or more staff for toileting.</p> <p>A recapitulation of physician's orders, signed 2/12/14, indicated Resident #28 had the following bowel protocol order:</p> <p>If no bowel movement in 48 hours give natural laxative (a mixture of prune juice, bran flakes, and applesauce), 2 tablespoons by mouth two times a day.</p> <p>If still no results in 24 hours give Milk of Magnesia (a laxative), 30 milliliters (ml) by mouth and continue natural laxative.</p>			

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	<p>If still no results in 12 hours insert 1 Dulcolax suppository (a laxative) 10 milligrams (mg), rectally. If still no results in 24 hours insert 1 enema rectally. If still no results after enema notify physician for further orders. The original date of this protocol was 1/21/14.</p> <p>The bowel movement records for March, 2014 indicated the resident did not have a bowel movement for 23 shifts from March 18 to March 26, 2014. A "1" had been documented in the "No Bowel Movement" column. This resulted in a time period of 7 days without a recorded bowel movement.</p> <p>The March, 2014 Medication Administration Record (MAR) indicated Milk of Magnesia had been given on March 2, and March 26, 2014. No other as needed bowel medications/interventions had been documented on the March, 2014 MAR.</p> <p>An "ELIMINATION CIRCUMSTANCE, REASSESSMENT AND INTERVENTION" form had been initiated on 3/24/14 for not having had a bowel movement in 3 days. The nursing notes lacked any information related to any further interventions having been given or tried during this time period.</p> <p>During an interview with the Assistant Director of Nursing (ADoN) on 3/28/14 at 2:00 p.m., additional information was requested related to the lack of bowel monitoring and interventions having been completed from March 18 to March 26, 2014. She indicated once a shift nurse prints out a bowel report. The bowel report lists the residents that have not had a bowel movement in 9 shifts. An "ELIMINATION</p>				

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	<p>CIRCUMSTANCE, REASSESSMENT AND INTERVENTION" form was then initiated for the listed residents and the residents were monitored for 3 days.</p> <p>During an interview with the ADoN on 3/28/14 at 2:41 p.m., she indicated she had no additional information to provide regarding the bowel monitoring for Resident #28.</p> <p>Review of the current facility policy, revised 12/4/12, titled "GUIDELINES BOWEL PROTOCOL," provided by the DoN on 3/28/14 at 8:00 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: To provide guidance for the use of bowel stimulants for resident with constipation.... ...PROCEDURE:...</p> <p>...5. The Bowel and Bladder Circumstance form shall be initiated for any resident not having a BM with 72 hours... ...a. An assessment of the abdomen shall be completed each shift that includes abdominal distention, pain and bowel sounds...."</p> <p>4.) The clinical record for Resident #79 was reviewed on 3/27/14 at 1:20 p.m. Diagnoses for Resident #79 included, but were not limited to, dementia, weakness, and arthritis.</p> <p>The hospice plan of treatment for Resident #79 indicated a Registered Nurse (RN) would visit the resident once a week. The clinical record for Resident #79 lacked a RN visit for March 5 and March 26, 2014.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 3/27/14 at 2:24 p.m., additional information was requested related to the hospice RN visits for</p>			

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	<p>Resident #79. She indicated she would contact the hospice office and request the information.</p> <p>The facility failed to provide any other information related to the lack of hospice RN visits for the resident as of exit on 3/31/14.</p> <p>5.) The clinical record for Resident #18 was reviewed on 3/26/14 at 3:21 p.m. Diagnoses for Resident #18 included, but were not limited to, extreme weakness, brainstem meningioma, anemia, and depression.</p> <p>The hospice plan of treatment for Resident #18 indicated a Registered Nurse (RN) would visit the resident once a week. The clinical record for Resident #18 lacked a RN visit for February 19, March 5, and March 26, 2014.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 3/27/14 at 2:24 p.m., additional information was requested related to the hospice RN visits for Resident #18. She indicated she would contact the hospice office and request the information.</p> <p>The facility failed to provide any other information related to the lack of hospice RN visits for the resident as of exit on 3/31/14.</p> <p>6.) The clinical record for Resident #36 was reviewed on 3/27/14 at 1:50 p.m. Diagnoses for Resident #36 included, but were not limited to, advanced dementia, chronic kidney disease, and hypertension.</p> <p>The hospice plan of treatment for Resident #36 indicated a Registered Nurse (RN) would visit the resident once a week. The clinical record for Resident #18 lacked a RN visit for</p>			

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F000323 SS=D	<p>February 18, March 4, and March 25, 2014.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 3/27/14 at 2:24 p.m., additional information was requested related to the hospice RN visits for Resident #36. She indicated she would contact the hospice office and request the information.</p> <p>The facility failed to provide any other information related to the lack of hospice RN visits for the resident as of exit on 3/31/14.</p> <p>3.1-37(a) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with a risk for choking was not served thinned liquids which put her at risk for 1 of 1 residents reviewed for provision of thickened liquids to prevent aspiration (Resident #54).</p> <p>Findings include:</p> <p>Resident #54's record was reviewed on 3/28/14 at 11:00 a.m. Resident #54's current diagnoses included, but were not limited to, Parkinson's disease, debility, and dementia. Resident #54 had a current, 3/2014, order for a mechanical soft diet with nectar thickened liquids.</p>	F000323	<p><b>F 323</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #54 observed during meal service to ensure she was served fluid consistency as ordered per MD.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will observe all 3 meal service times to ensure residents are served fluid</p>	

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	<p>Resident #54 had a current, 2/17/14, quarterly, Minimum Data Set (MDS) assessment which indicated the resident rarely made decisions, received a mechanically altered diet and required extensive assistance from one staff to eat.</p> <p>Resident #54 had a 4/30/13, most current, Speech Therapy note which indicated: "Patient was referred due to decline in oropharyngeal swallow....Diet was changed to mechanical soft with nectar thick liquids. Pt demonstrated inconsistent cough with thin liquids."</p> <p>During a 3/26/14, 12:25 p.m. to 12:30 p.m., lunch observation, CNAs #5 and #9 were passing drinks in the Restorative Dining Room.</p> <p>During a 3/26/14, 12:30 p.m., lunch observation, Resident #54 was drinking regular apple juice through a straw. At 12:32 p.m., CNA #9 removed the thin apple juice that Resident #54 was drinking and gave her thickened juice.</p> <p>During a 3/26/14, 12:45 p.m., interview CNA #9 indicated she had no idea how resident #54 received thinned apple juice.</p> <p>During a 3/26/14, 12:45 p.m., interview, CNA #5 indicated she did not know how Resident #54 got thinned liquids.</p> <p>3.1-45(a)(2)</p>		<p>consistency as ordered per MD.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> A list of all residents with altered fluid consistency orders will be available in Dining / Kitchen area. The list will be updated with changes as needed.</p> <p>DHS or designee will re-educate the staff on the following expectation: 1). All staff to verify resident's current fluid consistency orders prior to serving. A list of all residents with altered fluid consistency orders will be available in Dining / Kitchen area. The list will be updated with changes as needed.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for random meal service will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Observe meal service to ensure residents are served fluid consistency as ordered per MD 2). Review altered fluid consistency list to ensure it has been updated with any changes</p> <p>Throughout the audit / observation period, all 3 meal will</p>				

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident with a history of weight loss was offered dining assistance when needed for 1 of 5 residents reviewed for nutritional risk (Resident #80).</p> <p>Findings include:  Resident #80's record was reviewed on 3/25/14 at 3:13 p.m. Resident #80's current diagnoses included, but were not limited to, chronic pain and senile dementia. Resident #80 had a current, 3/14, order for a mechanical soft diet.</p>			F000325	<p>be observed.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> <p><b>F 325</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #80 was observed during all 3 meal service to ensure he was offered dining assistance when needed. <b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will observe all 3 meal services to ensure dining</p>		

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	<p>A current, 12/15/13, quarterly, Minimum Data Set (MDS) assessment indicated Resident #80 rarely made decisions, and required extensive assistance of one staff for eating.</p> <p>Resident #80 had a current 1/9/14 Nutrition Progress Note which indicated the resident had a 15% weight loss over a 6 month period.</p> <p>Resident #80 had a current 12/10/13 care plan problem regarding nutritional needs. Approaches to this problem included, but were not limited to, "assist me at meals as needed so that I may safely and as independently as possible consume any food and beverages served.</p> <p>During a 3/26/14, 12:33 p.m., lunch observation, Resident #80 was seated at the dining room table in a broda chair. His plate was in front of him on the table. The plate was approximately 3 inches from the edge of the table. When seated with his back against the back of the chair, Resident #80 could not reach all the items on his plate. He used his knife and drug a dinner roll to within reach. He ate the dinner roll. He used his knife and stretched and reached the casserole from the far side of his plate. He ate the casserole off his knife. Resident #80 could successfully reach about 1/3 of his plate. He ate all the food located on that 1/3 section of his plate. At no time did any staff member assist Resident #80 to reach his plate or obtain the food items which were out of reach. At 12:50 p.m., CNA #9 was requested to turn Resident #80's plate and move it within reach (17 minutes after the meal was served). After the meal was positioned within reach, Resident #80 was able to eat 75% of his meal.</p>		<p>assistance is offered to residents when needed.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following expectation: Dining Assistance <b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for meal service will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Observe random meal services to ensure dining assistance is offered to residents when needed.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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F000332 SS=D	<p>During a 3/28/14, 9:10 a.m. interview, the MDS Coordinator indicated the care plans do not have individualized approached or information, such as the resident can drink fluids from a cup if handed to her but she needs fed her meal. The care plans expect the staff to watch the residents each meal and observe what they need.</p> <p>3.1-46(a)(1) 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure it was free from a medication error rate of less than 5% during the medication administration task. Two errors in receiving medications were observed during 30 opportunities for error in medication administration. This resulted in a medication error rate of 6%. (Resident #68 and #49)</p> <p>Findings include:</p> <p>1.) During an observation on 3/27/14 at 7:18 a.m., LPN #1 was observed to administer Resident #68 his morning medications. The Sensipar was crushed before administration.</p> <p>Manufacturer's directions from the *****"Nursing 2014 Drug Handbook," included but were not limited to: "Don't break or crush tablets; give them whole, with food or shortly after a meal."</p>	F000332	<p><b>F 332</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #68 and #49 - A observation of medication administration was conducted to ensure the medication error rate is less than 5%. Includes review of Medication Crush Guidelines and Medications administered per order.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will conduct a medication administration observation on all 3 shifts to ensure the medication error rate is less than 5%. Includes review</p>	

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	<p>A list of "MEDICATIONS NOT TO BE CRUSHED", from the Medication Administration Record (MAR), included Sensipar.</p> <p>During an interview with LPN #1, on 3/31/14 at 9:25 a.m., LPN #1 indicated she did not read the "do not crush" instructions on the medication label. She indicated the Sensipar should not have been crushed. This resulted in one medication error.</p> <p>The clinical record for Resident #68 was reviewed on 3/27/14 at 9:06 a.m. Diagnoses for Resident #68 included, but were not limited to, hypercalcemia, hypertension, and dementia.</p> <p>Current physician's orders, signed 2/12/14, for Resident #68 included, but were not limited to, the following order:</p> <p>Sensipar (calcium absorption medication) 90 milligrams (mg) give 1 tablet orally 2 times a day.</p> <p>2.) During an observation on 3/27/14 at 8:22 a.m., LPN #3 was observed to administer Resident #49 his morning medications. Resident #49 received 2 tablets of potassium 20 milliequivalents by mouth.</p> <p>The clinical record for Resident #49 was reviewed on 3/27/14 at 1:05 p.m. Diagnoses for Resident #49 included, but were not limited to, hypertension, muscle cramps, and atrial fibrillation.</p> <p>Current physician's orders, signed 2/12/14, for Resident #49 did not include an order for potassium. The MAR included a hand written order for potassium 40 milliequivalents (meq)</p>		<p>of Medication Crush Guidelines and Medications administered per order.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following guideline: Specific Medication Administration Guideline. Includes review of Medication Crush Guidelines and Medications administered per order.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for Medication Administration will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Conduct a medication administration observation to ensure the medication error rate is less than 5%. Includes review of Medication Crush Guidelines and Medications administered per order.</p> <p>Throughout the audit / observation period, all 3 shifts will be observed.</p> <p>The results of the audit</p>				

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	<p>by mouth three times a day.</p> <p>A telephone order, dated 1/14/14, indicated "...change current potassium 40 meq TID (three times a day) to potassium 40 meq QID (four times a day) x 3 days, recheck on Monday 1/20/14...."</p> <p>The lab results, dated 1/20/14, indicated the provider had addressed another laboratory report with new orders. No orders for the potassium level were indicated on the lab result. The nurses notes did not contain any information related to the 1/20/14 potassium lab results.</p> <p>During an interview with the Director of Nursing (DoN), on 3/27/14 at 2:24 p.m., the DoN indicated RN #4 wrote the 1/14/14 telephone order and assumed the potassium would resume to the previous order before the lab draw.</p> <p>During an interview with LPN #3, on 3/31/14 at 9:16 a.m., LPN #3 indicated after a lab check related to a medication change, the nurse must get a resume previous dosage order or a new order for the medication from the physician. She further indicated the nurse cannot assume the medication order remained the same. This resulted in one medication error.</p> <p>3.) Review of the current facility policy, dated 9/1/13, titled "SPECIFIC MEDICATION ADMINISTRATION PROCEDURES," provided by the DoN on 3/28/14 at 10:20 a.m., included, but was not limited to, the following:</p> <p>...2) Consult "Crush Guidelines" before crushing tablets...</p>		<p>observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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F000371 SS=E	<p>...MEDICATIONS THAT SHOULD NOT BE CRUSHED OR CHEWED... ...the nurse administering the medication should check to see that there is no contraindication to crushing the medications in question...."</p> <p>4.) Two errors divided by thirty opportunities for error times 100 resulted in a medication error rate of 6%.</p> <p>3.1-25(b)(9) 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</p> <p>Based on observation, interview and record review, the facility failed to ensure food was served in a safe sanitary manner for 2 of 2 meal observations (3/24/14 lunch and 3/26/14 lunch) regarding the uncovered food items and hand washing when distributing room trays and a confused resident handling other residents' food, utensils and table clothes. This deficient practice had the potential to impact 2 residents who dined with a confused resident in the Restorative Dining Room (Residents #94 and #22) and 22 of 22 residents who received room trays.</p> <p>Findings include:</p> <p>1. During a 3/24/14, lunch meal observation, Resident #68 was seated at a dining room</p>	F000371	<p><b>F 371</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> 1). Room (hall tray) service observed for all 3 meals and all 3 hallways will be observed to ensure food is served in a safe sanitary manner. Include observing for the following: ensure all items on top of and inside delivery cart are covered and appropriate hand washing procedures take place.</p> <p>2). Observation of all 3 meal to ensure residents do not</p>				

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	<p>table as if ready to dine. Resident #68 sat facing the table for 19 minutes. During this 19 minutes Resident #68 removed the table cloth and tossed it to the center of the table. Tossed his silverware and his table mates' silverware on top of the ruffled table cloth. Then manipulated and tossed the table cloth about on and off for the complete 19 minute period.</p> <p>During a 3/24/14, 12:30 p.m. Restorative Dining lunch observation, CNA #5 straightened the table cloth Resident #68 had tossed to the center of the table and manipulated during the time he waited and placed the same handled table cloth on the table were Residents #22, #94 and #68 were dining. CNA #5 then gave the silverware which was closest to each resident to that resident. Resident #68 had handled the silverware which was given to Resident #94.</p> <p>During a 3/24/14, 12:33 p.m., lunch observation, Resident #22's glass of thickened liquid was placed on the table out of his line of sight. At 12:37 p.m. Resident #68 grabbed Resident #22's glass putting his fingers inside the cup. Resident #68 moved the glass and placed it in front of Resident #94.</p> <p>During a 3/24/14, 12:40 p.m., observation, CNA #7 took the glass of thickened liquids Resident #68 had placed his hand in and served it to Resident #22.</p> <p>During a 3/24/14, 12:45 p.m., interview, CNA #7 indicated she did not consider how Resident #22's glass had gotten to the other side of the table. She just knew the glass with thickened liquids was his so she gave it to him.</p>		<p>manipulate the table settings such as table cloths, silverware, drinking glasses. If items are manipulated, ensure they are replaced before use.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by this alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the dietary and nursing staff on the following guideline: 1). Department Brand Standard: In - room dining 2). Guidelines for hand washing</p> <p>DHS or designee will re-educate the nursing staff on the following expectation: A staff member will be assigned to the Restorative Dining Room upon residents arrival to provide pre-meal diversionary interaction. In addition, the staff member will also monitor to ensure residents do not manipulate the table settings such as table cloths, silverware, drinking glasses. If any items are manipulated by a resident, they will be replaced.</p> <p><b>How the corrective measures</b></p>				

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	<p>During a 3/24/14, 12:43 p.m., interview, CNA #5 indicated she should have gotten a clean tablecloth and clean silverware for Residents #22, #94 and #68. She indicated she had not considered they had been touched by a resident.</p> <p>2. Hall trays were observed being passed on 3/24/14. The tray cart arrived on the 300 hall at 12:28 p.m. There was a pitcher of ice water and a bowl of ice on the top of the cart that were not covered. Trays were passed to the 300 hall and at 12:33 p.m., the cart was pushed to the 200 hall by dietary staff #6. Dietary staff #6 was wearing gloves while pushing the cart. After arriving on the 200 hall, dietary staff #6 moved a soiled breakfast tray from the top of a three tier cart to the bottom shelf. While wearing the same gloves, she began setting up trays to be served on the 200 hall. At 12:39 p.m., a resident at the end of the hall requested a glass of water. Dietary staff #6 filled a glass with ice from the uncovered bowl of ice and poured water into the glass from the uncovered pitcher of water. She placed the uncovered glass of water on the counter at the nurse station and told LPN #8 who it was for. LPN #8 served the glass of water at 12:44 p.m. The glass had sat uncovered at the nurses station for five minutes.</p> <p>3. On 3/ 26/14 at 12:26 p.m., dietary staff #10 delivered the tray cart to the 300 hall. She prepared hall trays with gloved hands. Two hall trays were carried down the hall with uncovered cupcakes. The dietary staff #10 scratched her left arm with her right gloved hand and continued to prepare hall trays to be served to residents.</p>		<p><b>will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations of dining room and room service (hall trays) meal service will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>1). Observe room service (hall trays) to ensure food is served in a safe sanitary manner. Include observing for the following: ensure all items on top of and inside delivery cart are covered and appropriate hand washing procedures take place. 2). Observe dining room meal service to ensure replacing of table settings such as table cloths, silverware, drinking glasses if any items are manipulated by residents. 3). Observe dining room to ensure a staff member is assigned to the Restorative Dining Room upon resident's arrival and the staff member provides pre-meal diversionary interaction.</p> <p>Throughout the audit / observation period, all 3 meal services for the dining room and room service (hall trays) will be observed.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for</p>				

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F000514 SS=D	<p>4. During an observation of the lunch hall tray pass on 3/24/14 at 12:27 p.m., Dietary Aide # 10 was observed wearing the same pair of gloves throughout the tray pass for 3 different halls (22 residents) without changing gloves or washing her hands between resident contact. The plates were located in the cart without covers.</p> <p>5. On 3/31/14 at 9:05 a.m., the Dietary Manager provided an undated policy entitled "Department Brand Standard: In-Room Dining".</p> <p>"In-Room Dining standards meet Triology Health Services brand requirements in their administration and include policies outlining:...</p> <p>In-Room Dining: Features and Functionality Policy and Procedures Campus and Team Member 'Best Practice'...</p> <p>Meals are prepared in the kitchen from choices the customer made on the cafe menu.</p> <p>Hot foods are placed on heated plates and covered with stainless steel covers..."</p> <p>3.1-21(i)(3) 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</p>		a minimum of 6 months then randomly thereafter for further recommendation.				

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	<p>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 residents' clinical records contained complete and accurate documentation for 2 of 30 residents reviewed for complete records. (Resident #89 and #53).</p> <p>Findings include:</p> <p>1.) Resident #89's clinical record was reviewed on 3/26/14 at 9:25 a.m. The resident's diagnoses included, but were not limited to, chronic renal failure, severe debility, chronic pain and end stage renal disease.</p> <p>The record indicated the resident had a fistula in his right arm and went out for dialysis on Mondays, Wednesdays and Fridays.</p> <p>Review of the resident's clinical record lacked documentation of times when the resident was out of the facility for dialysis. The dialysis center provided a communication form to send with the resident for each visit. The form included a space to be completed for when the resident left and returned to the facility. The space was left blank on all of the forms.</p> <p>During an interview on 3/26/14 at 10:45 a.m., with LPN # 1, she indicated the dialysis communication forms were to be sent with the resident every visit to the dialysis center</p>	F000514	<p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Resident #89 and #53 - review of clinical record to ensure documentation is complete for the times when the resident is out of the facility. Includes review of the dialysis communication form to ensure the times are documented when the resident leaves / returns to the campus.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> All residents have the potential to be affected by the alleged deficient practice.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the Licensed Nurses on the following guideline: 1). Signing Residents Out. 2). For dialysis residents, includes documentation on the dialysis communication form to ensure the times are documented</p>	04/30/2014			

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	<p>and should have been completed. She indicated there had been some new nurses lately and they didn't know what to do.</p> <p>During an interview on 3/27/14 at 12:40 a.m., with the Director of Nursing she indicated the dialysis communication forms should have been completed with the time the resident left the facility and the time the resident returned to the facility. She indicated residents were to be signed out on the "Release of Responsibility For Leave Of Absence" form when they left the facility for an appointment.</p> <p>During an interview with Nurse Supervisor #11 on 3/31/14 at 10:10 a.m., she indicated nurses should chart when residents left for an appointment in the LOA [Leave of Absence] Book.</p> <p>On 3/31/14 at 3:30 p.m., the Medical Records LPN provided the "Release of Responsibility for Leave of Absence" for Resident #89. She indicated Resident #89 had only been signed out for dialysis one time and that was on 3/31/14.</p> <p>2.) Resident #53's clinical record was reviewed on 3/27/14 at 10:17 a.m. The resident's diagnoses included, but were not limited to, dementia, confusion, incontinence, and hypertension with cardiac arrhythmia.</p> <p>Review of Resident #53's Nurse's notes indicated the resident had an injection on 3/10/14. Review of the Medication Administration Record and Physician's Orders lacked an indication of an injection being given.</p> <p>A 3/10/14, 3:30 p.m., Physician's note indicated the resident was out of the facility at</p>		<p>when the resident leaves / returns to the campus.</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations for 5 residents per hallway, including all dialysis residents, will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:</p> <p>1). Review of the clinical record to ensure documentation is complete for the times when the resident is out of the facility. 2). For dialysis residents, includes review of documentation on the dialysis communication form to ensure the times are documented when the resident leaves / returns to the campus.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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F000520 SS=E	<p>a physician's appointment at that time.</p> <p>On 3/31/14 at 3:30 p.m., the Medical Records LPN provided the "Release of Responsibility for Leave of Absence" for Resident #53. She indicated Resident #53 had never been signed out for an appointment.</p> <p>3.) The 10/19/07, revised "Procedure Guidelines Signing Residents Out" was provided by the Director of Nursing on 3/28/14 at 10:20 a.m., and indicated the purpose was to ensure staff had knowledge of residents that are out of the facility. The procedure indicated the following: "...1. Each resident leaving the premises (excluding transfers/discharges) shall be signed out. 2. A sign-out register will be located at the nurses' station. Registers must indicate the resident's expected time of return....9. Residents shall sign in upon return to the facility...."</p> <p>3.1-50(a)(1) 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p>						

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	<p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on record review and interview, the facility's Quality Assessment and Assurance Committee failed to identify and address the lack of visits by the Hospice Nurse and the lack of Nursing Notes by the Hospice Nurse for 3 of 4 residents reviewed for hospice services. (Resident #79, #18, and #36</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #79 was reviewed on 3/27/14 at 1:20 p.m. Diagnoses for Resident #79 included, but were not limited to, dementia, weakness, and arthritis.</p> <p>The hospice plan of treatment for Resident #79 indicated a Registered Nurse (RN) would visit the resident once a week. The clinical record for Resident #79 lacked a RN visit for March 5 and March 26, 2014.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 3/27/14 at 2:24 p.m., additional information was requested related to the hospice RN visits for Resident #79. She indicated she would contact the hospice office and request the information.</p> <p>The facility failed to provide any other information related to the lack of hospice RN</p>	F000520	<p><b>F 520</b></p> <p><b>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:</b> Residents #79, #18 and #36 - review to ensure Hospice Nurse visits are completed as contracted.</p> <p><b>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:</b> DHS or designee will complete the following: Review of all residents receiving hospice services to ensure Nurse visits are completed as contracted.</p> <p><b>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:</b> DHS or designee will re-educate the nursing staff on the following guideline: Hospice Services / Nurse visit documentation as contracted</p>	04/30/2014

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	<p>visits for the resident as of exit on 3/31/14.</p> <p>2.) The clinical record for Resident #18 was reviewed on 3/26/14 at 3:21 p.m. Diagnoses for Resident #18 included, but were not limited to, extreme weakness, brainstem meningioma, anemia, and depression.</p> <p>The hospice plan of treatment for Resident #18 indicated a Registered Nurse (RN) would visit the resident once a week. The clinical record for Resident #18 lacked a RN visit for February 19, March 5, and March 26, 2014.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 3/27/14 at 2:24 p.m., additional information was requested related to the hospice RN visits for Resident #18. She indicated she would contact the hospice office and request the information.</p> <p>The facility failed to provide any other information related to the lack of hospice RN visits for the resident as of exit on 3/31/14.</p> <p>3.) The clinical record for Resident #36 was reviewed on 3/27/14 at 1:50 p.m. Diagnoses for Resident #36 included, but were not limited to, advanced dementia, chronic kidney disease, and hypertension.</p> <p>The hospice plan of treatment for Resident #36 indicated a Registered Nurse (RN) would visit the resident once a week. The clinical record for Resident #18 lacked a RN visit for February 18, March 4, and March 25, 2014.</p> <p>During an interview with the Assistant Director of Nursing (ADoN), on 3/27/14 at 2:24 p.m., additional information was requested related to the hospice RN visits for</p>		<p>DHS or designee will re-educate the Quality Assurance Committee on the following guideline: Quality Assessment and Assurance Process</p> <p><b>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:</b> The following audits and /or observations will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Review of all residents receiving hospice services to ensure Nurse visits are completed as contracted. 2). Review of Quality Assessment and Assurance minutes to ensure the results of the audit and / or observations are reported, reviewed and trended for compliance thru the campus Quality Assurance Committee.</p> <p>The results of the audit and / or observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>		

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	<p>Resident #36. She indicated she would contact the hospice office and request the information.</p> <p>The facility failed to provide any other information related to the lack of hospice RN visits for the resident as of exit on 3/31/14.</p> <p>4.) During an interview with the Administrator on 3/31/14 at 9:10 a.m., he indicated Hospice services had not been reviewed by the Quality Assessment and Assurance Committee.</p> <p>3.1-52(b)(2)</p>			