

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155042	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2014
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NAME OF PROVIDER OR SUPPLIER WILLOW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 3801 OLD BRUCEVILLE RD BOX 136 VINCENNES, IN 47591
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 7, 8, 9, 13, 14, 2014</p> <p>Facility number: 000016 Provider number: 155042 AIM number: 100291500</p> <p>Survey team: Dorothy Watts, RN TC Terri Walters, RN Amy Wininger, RN Sylvia Martin, RN 5/7, 5/8, 5/13, 5/14</p> <p>Census bed type: SNF: 16 SNF/NF: 121 Total : 137</p> <p>Census payor type: Medicare: 22 Medicaid: 98 Other: 17 Total: 137</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 19, 2014 by Jodi Meyer, RN</p>	F000000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective June 13, 2014 to the annual licensure survey conducted on May 7, 2014 through May 14, 2014.	

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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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F000225	F225	06/13/2014			

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	<p>Based on observation, interview, and record review, the facility failed to ensure allegations of abuse were reported within the required time frame to a State agency, in that, allegations of abuse were not immediately reported to the ISDH (Indiana State Department of Health) for 2 of 3 abuse allegations reviewed and 1 of 3 allegations were not immediately reported to the Administrator. (Resident #160, Resident #188)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an interview on 05/08/14 at 1:30 P.M., Resident #160 was observed sitting in a reclining chair and indicated at that time, an abusive situation between two residents had been witnessed a few days before and was reported to facility staff by another resident. 2. During an interview on 05/08/14 at 1:36 P.M., Resident #188 was observed in the dining room sitting in a stationary chair and indicated during an interview, at that time, an episode of abuse had been witnessed between another resident in the facility and a visitor earlier in the week. Resident #188 further indicated, at that time, the Social Services Director was notified of the incident. <p>During an interview on 05/08/14 at 1:50</p>		<p>It is the practice of this facility to assure that allegations of abuse are reported to the administrator and to the appropriate agencies as identified per the regulation</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>There have been no further abuse allegations that have been reported at this time. The policy related to abuse has been revised to identify immediate notification of ISDH of any allegations of abuse.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>Potentially all residents could be affected. The policy has been revised to reflect immediate notification of ISDH of allegations of abuse. There have been no allegations or observations of incidents of abuse with any other residents.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>The policy related to reporting of abuse has been revised to include immediate notification of ISDH of allegations of abuse. All staff has been in-serviced related to the revision in the policy and to assure a thorough understanding of the regulation including the reporting of abuse to the facility Administrator immediately thus to other appropriate agencies as required by</p>	

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	<p>P.M., the HFA (Health Facilities Administrator) provided a list of events that were reported to the ISDH in the previous 90 days. The list lacked any documentation related to the allegations made by Resident #160 and/or Resident #188. The HFA was notified of the abuse allegations on 05/07/14 at 1:55 P.M. and indicated, at that time, the investigations would be started immediately.</p> <p>An Indiana State Department of Health Division of Long Term Care Incident Report Form dated 05/09/14 indicated an allegation of resident to resident abuse was reported to the HFA on 05/08/14 at approximately 2:00 P.M. The form further indicated the HFA reported the allegation to the ISDH on 05/09/14 at 11:34 A.M. (21 hours and 34 minutes)</p> <p>An Indiana State Department of Health Division of Long Term Care Incident Report Form dated 05/09/14 indicated an allegation of visitor to resident abuse was reported to facility staff on 05/05/14 at 12:15 P.M. The form further indicated the DON (Director of Nursing) reported the allegation to the ISDH on 05/09/13 at 1:12 P.M. (4 days and 57 minutes)</p> <p>During an interview on 05/09/14 at 10:30 A.M., the HFA indicated staff did not immediately make her aware of the</p>		<p>the regulation.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that will be utilized to review the proper following of the abuse policy including notification of the appropriate state agencies in a timely manner. It is the Administrator's responsibility to assure that the appropriate agencies are notified of any allegations in a timely manner. The Administrator, or designee, will complete this audit monthly x3, then quarterly x3. Any identified issues will be immediately addressed as needed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcomes of the tool</p> <p>The date the systemic changes will be completed:</p> <p>June 13, 2014</p>		

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	<p>allegations of abuse and the allegations of abuse were not reported to the ISDH immediately.</p> <p>During an interview on 05/09/14 at 2:00 P.M., the HFA indicated the resident to resident abuse allegation had been unsubstantiated, and was reported to the ISDH on 05/09/14 at 11:34 A.M., she was not aware the ISDH should be notified immediately of all allegations of abuse and that she thought it was within 24 hours. The HFA then indicated the visitor to resident abuse had not been reported to her immediately.</p> <p>The Abuse Prevention Policy provided by the HFA on 05/07/14 at 11:30 A.M., indicated, "...Policy Statement...Abuse Investigations 10. Should the investigation real that abuse occurred, the Administrator or designee will report such findings to...the state licensing agency ...within 24 hours of the results of the completion of the investigation...Allegation of abuse are reported to the state survey agency within 24 hours...Reporting Abuse...2. Employees, facility consultants and/or attending physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately...4. When an alleged or suspected case of mistreatment, neglect,</p>			

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F000226 SS=D	<p>injuries of an unknown source or abuse is reported, the facility Administrator.....will notify the following persons or agencies of such incident...a. The State licensing/certification agency responsible for surveying/licensing the facility..." The policy lacked any documentation related to the Administrator and/or Designee to immediately notify the ISDH of all allegations of abuse..."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the abuse policy was implemented, in that the State agency was not immediately notified of abuse allegations for 2 of 3 abuse allegations reviewed. (Resident #160, Resident #188)</p> <p>Findings include:</p>	F000226	<p>F226</p> <p>It is the practice of this facility to assure that the Administrator is notified immediately related to allegation of abuse, neglect, or misappropriation of property. The Administrator is then responsible for notifying the appropriate agencies as required in a timely manner per the facility policy and the regulation</p>	06/13/2014

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	<p>1. During an interview on 05/08/14 at 1:30 P.M., Resident #160 was observed sitting in a reclining chair and indicated at that time, an abusive situation between two residents had been witnessed a few days before and was reported to facility staff by another resident.</p> <p>2. During an interview on 05/08/14 at 1:36 P.M., Resident #188 was observed in the dining room sitting in a stationary chair and indicated during an interview, at that time, an episode of abuse had been witnessed between another resident in the facility and a visitor earlier in the week. Resident #188 further indicated, at that time, the Social Services Director was notified of the incident.</p> <p>During an interview on 05/08/14 at 1:50 P.M., the HFA (Health Facilities Administrator) provided a list of events that were reported to the ISDH in the previous 90 days. The list lacked any documentation related to the allegations made by Resident #160 and/or Resident #188. The HFA was notified of the abuse allegations on 05/07/14 at 1:55 P.M. and indicated, at that time, the investigations would be started immediately.</p> <p>An Indiana State Department of Health Division of Long Term Care Incident</p>		<p>The correction action taken for those residents found to be affected by the deficient practice include: There have been no additional allegations for reporting at this time. Please refer to systematic changes related to the policy and reporting mechanisms to the Administrator and the appropriate state agencies in a timely manner.</p> <p>Other residents that have the potential to be affected have been identified by: There have been no incidents of abuse related to any additional residents. Potentially all residents could be affected and therefore the current policy has been revised with the appropriate training of staff on the revised policy.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The policy related to the prevention and the reporting of any form of abuse has been revised to include timely notification of ISDH in accordance with the regulation. All staff has been in-serviced on the policy to assure a thorough understanding of the regulation including the immediate notification of the Administrator and the reporting of allegations of abuse in a timely manner to the appropriate agencies.</p> <p>The corrective action taken to monitor performance to assure</p>		

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	<p>Report Form dated 05/09/14 indicated an allegation of resident to resident abuse was reported to the HFA on 05/08/14 at approximately 2:00 P.M. The form further indicated the HFA reported the allegation to the ISDH on 05/09/14 at 11:34 A.M. (21 hours and 34 minutes)</p> <p>An Indiana State Department of Health Division of Long Term Care Incident Report Form dated 05/09/14 indicated an allegation of visitor to resident abuse was reported to facility staff on 05/05/14 at 12:15 P.M. The form further indicated the DON (Director of Nursing) reported the allegation to the ISDH on 05/09/13 at 1:12 P.M. (4 days and 57 minutes)</p> <p>During an interview on 05/09/14 at 10:30 A.M., the HFA indicated staff did not immediately make her aware of the allegations of abuse and the allegations of abuse were not reported to the ISDH immediately.</p> <p>During an interview on 05/09/14 at 2:00 P.M., the HFA indicated the resident to resident abuse allegation had been unsubstantiated, and was reported to the ISDH on 05/09/14 at 11:34 A.M., she was not aware the ISDH should be notified immediately of all allegations of abuse and that she thought it was within 24 hours. The HFA then indicated the</p>		<p>compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that will be utilized to review reportable events to assure that they are reported timely in accordance with the facility policy and the regulation. It is the Administrator's responsibility to assure that the appropriate agencies are notified of any allegations in a timely manner. The Administrator, or designee, will complete this audit monthly x3, then quarterly x3. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed.</p> <p>The date the systemic changes will be completed: June 13, 2014</p>				

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	<p>visitor to resident abuse had not been reported to her immediately.</p> <p>The Abuse Prevention Policy provided by the HFA on 05/07/14 at 11:30 A.M., indicated, "...Policy Statement...Abuse Investigations 10. Should the investigation real that abuse occurred, the Administrator or designee will report such findings to...the state licensing agency ...within 24 hours of the results of the completion of the investigation...Allegation of abuse are reported to the state survey agency within 24 hours...Reporting Abuse...2. Employees, facility consultants and/or attending physicians must report any suspected abuse, allegations of abuse, or incidents of abuse to the Administrator immediately...4. When an alleged or suspected case of mistreatment, neglect, injuries of an unknown source or abuse is reported, the facility Administrator.....will notify the following persons or agencies of such incident...a. The State licensing/certification agency responsible for surveying/licensing the facility..."</p> <p>The policy lacked any documentation related to the Administrator and/or Designee to immediately notify the ISDH of all allegations of abuse..."</p> <p>3.1-28(c)</p>						

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review the facility failed to ensure services were provided to a dependent resident, in that a resident who required assistance with oral care did not receive assistance with oral care for 1 of 3 residents who met the criteria for review of ADL's (Activities of Daily Living). (Resident #95)</p> <p>Findings include:</p> <p>During an interview on 05/08/14 at 11:10 A.M., Resident #95 indicated he needed staff assistance for oral care and had not received any assistance with oral care, "...for a long time...I don't even have a toothbrush or toothpaste...at least they should set me up and help me get started...". Resident #95 was observed, at that time, to have white debris along the gum line and foul mouth odor. Mouth care supplies were observed, at that time, to not be in the resident's room or bathroom.</p>	F000312	<p>F312</p> <p>It is the practice of this facility to assure that the all residents receives necessary services to maintain good personal and oral hygiene.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #95 is receiving appropriate assistance related to oral care.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents have been reviewed to assure that they have all necessary supplies and services for daily oral care.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>The nursing staff has been in-serviced related to assuring that residents receive proper supplies and assistance for oral care daily.</p> <p>Please see monitoring systems below to assure that this issue does not reoccur.</p>	06/13/2014			

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	<p>During an interview on 05/13/14 at 10:10 A.M., Resident #95 was observed sitting in a wheelchair, propelling himself through the dining room. The mouth of Resident #95 was observed, at that time, to have white debris and foul mouth odor. Resident #95 further indicated, at that time, his teeth had not been brushed since he got up that morning.</p> <p>On 05/13/14 at 10:13 A.M., mouth care supplies were observed to not be in the resident's room or bathroom.</p> <p>During an interview on 05/13/14 at 10:15 A.M., CNA #1 indicated mouth care had been provided to Resident #95 that morning during A.M. care and the supplies had been thrown away.</p> <p>The clinical record of Resident #95 was reviewed on 05/13/14 at 9:43 A.M. The record indicated the diagnosis of Resident #95 included, but were not limited to, Parkinson's.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 02/05/14 indicated Resident #95 experience no cognitive impairment, extensive assist of two staff for hygiene and/or experienced no episodes of refusing care.</p>		<p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that will randomly reviews 5 residents to assure that oral care is being provided appropriately to the residents. The form will assure supplies available, and either through interview and/or observation to assure that oral care has been provided. The Director of Nursing, or designee, will complete this audit weekly x3, monthly x3, and then quarterly x3. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the audit.</p> <p>The date the systemic changes will be completed: June 13, 2014</p>	

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	<p>A Plan of Care dated 04/29/14 for "Self care deficit: all ADL's... related to: weakness" included, but was not limited to, interventions of "...extensive assist with ADL's...mouth care bid (twice daily) and prn (as needed)..."</p> <p>The May 2014 CNA - ADL documentation form indicated Resident #95 received oral care once daily from May 1 through May 13, 2014.</p> <p>A Nurse's note dated 05/01/14 at 1330 (1:30 P.M.) indicated, "...A (assist) of 2 for ADL's..."</p> <p>A Nurse's note dated 05/03/14 at 1330 indicated, "...Is A of one for ADL's..."</p> <p>A Nurse's note dated 05/04/14 at 1325 (1:25 P.M.) indicated, "...A of one with ADL's..."</p> <p>During an interview on 05/13/14 at 10:20 A.M., the Unit Manager #1 (UM #1) indicated mouth care should have been provided according to the care plan</p> <p>The Policy and Procedure for oral Hygiene provided by the Director of Nursing (DON) on 05/14/14 at 11:15 A.M. indicated, "...8. If the resident needs assistance, brush the teeth for him/her..."</p>			

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F000323 SS=G	<p>3.1-38(a)(3)(c)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure effective safety interventions and/or supervision were provided, in that, effective interventions were not implemented to prevent further falls, for a resident identified as having cognitive impairment with intermittent confusion and the resident experienced 3 falls for 1 of 4 residents who met the criteria for review of falls. This deficient practice resulted in the resident experiencing a hip fracture. (Resident #100)</p>	F000323	<p>F323</p> <p>It is the practice of this facility to assure that all fall interventions are in place in accordance with the residents' plans of care. It is also the practice of this facility to assure that proper supervision is provided at meal time for those residents that are at risk.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i> Resident #100 has been reviewed and has appropriate fall prevention interventions in place. Resident #135 is receiving supervision during meal service to assure safety and resident #168 has</p>	06/13/2014

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	<p>B. Based on observation, interview, and record review, the facility failed to ensure supervision was provided during meal time, in that, 2 residents who required aspiration precautions were not monitored during a meal for 1 of 4 residents in the A unit dining room during 1 of 2 meal observations (Resident # 135) and for 1 of 6 residents in the C/D unit dining room during 1 of 2 meal observations. (Resident #168)</p> <p>Findings include:</p> <p>A. During an interview on 05/07/14 at 2:37 P.M., Resident #100 was observed lying in bed and stated, "...I broke my leg here and had surgery..."</p> <p>The clinical record of Resident #100 was reviewed on 05/13/14 at 3:00 P.M. The record indicated Resident #100 was admitted on 03/25/14 with diagnoses including, but not limited to, "...CVA (Cerebrovascular Accident) (stroke) with right sided weakness...multiple episodes of syncope (fainting)...mild dementia (slight progression after this event)...". The record further indicated Resident #100 had experienced multiple falls after admission to the facility.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 03/31/14 indicated</p>		<p>been discharged.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents have been reviewed to assure that if they are at risk of falls that appropriate interventions are in place.</p> <p>All residents have been reviewed to assure that if supervision is required during meal service that it is provided.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>At the time of admission, with a significant change, and quarterly, the resident will be assessed for falls. If based on the assessment the resident is identified as being at risk for falls, interventions will be implemented. The interdisciplinary team will be reviewing every fall to assure that appropriate interventions are in place based on the possible cause of the fall. The plan of care and the CNA assignment sheets will be updated as needed.</p> <p>The nursing staff has been in-serviced related to fall preventions and assuring that interventions are in place to assist with the prevention of falls. The in-service will also include assuring that if certain interventions are not effective related to the resident being non-compliant, that the resident be reviewed for alternative</p>	

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	<p>Resident #100 experienced mild cognitive impairment, limited range of motion to one side of the body, and required assistance with balance during walking. The assessment further indicated Resident #100 had experienced a fall with injury since admission to the facility.</p> <p>The Physician's Admission Orders dated 03/25/14 included, but were not limited to, an order for, "...up with assist as tolerated..." and lacked any orders related to safety devices.</p> <p>The Admission Nursing Assessment dated 03/25/14 indicated Resident #100 required 1 (one) person assist with ambulation and included a handwritten notation, "slightly flaccid CVA right side". The form further indicated Resident #100 was alert and oriented to person, place, time and experienced confusion during the assessment.</p> <p>A Fall Risk Assessment dated 03/25/14 indicated Resident #100 experienced a balance problem while standing and walking, decreased muscular coordination, problems walking through doorway, jerking/unstable making turns, required assistive device and was a high risk to experience a fall.</p>		<p>interventions with the goal continuing to be fall prevention. If a resident is determined by nursing or if recommendations by Speech Therapy indicate a resident is at risk during meal time for aspiration or choking, interventions will be implemented to assure that meal service is provided in a supervised setting. If the resident requires supervision, staff will be present in the dining room until such time as the resident is finished with the meal. The nursing staff has been in-serviced related to the requirements that the staff must be present in the dining room if there is a resident that is considered at risk for aspiration or choking until the completion of their meal. Staff members will be assigned for meal monitoring and it has been reinforced that they are not to leave the area until those residents that are at risk for aspiration have completed their meal.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents who have had falls or are at risk for falls per their assessment to assure that appropriate interventions are in place to assist with the prevention of future falls. The form will also review for</p>				

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	<p>The Plan of Care lacked any documentation related to a care plan for prevention of falls and/or safety precautions before 03/26/14.</p> <p>A Nurse's note dated 03/25/14 at 11:30 (A.M./P.M. not specified) indicated Resident #100 was admitted to the facility and lacked any documentation safety interventions were implemented to ensure the safety of Resident #100.</p> <p>Fall #1: A Nurse's note dated 03/26/14 at 0400 (4:00 A.M.) indicated, "CNA entered room noted res (resident) on floor...several skin tears noted to bilateral arms...Res stated, 'I came out of bathroom and just went down...' The note lacked any documentation related to safety equipment or an immediate intervention being initiated to ensure the safety of Resident #100.</p> <p>A Fall Risk Assessment dated 03/26/14 indicated Resident #100 was not at a high risk to experience a fall.</p> <p>A Rehab (Rehabilitation) Screen dated 03/26/14 indicated Resident #100 experienced a decline in cognition and "decrease in safety and problem solving..."</p>		<p>alternative interventions if the resident is noncompliant with the current interventions. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected.</p> <p>A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents that are identified as being at risk for aspiration or choking. The form for auditing will assure that those residents have proper supervision until the completion of their meal. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected.</p> <p>The Quality Assurance Committee will review the tools for both fall prevention and supervision during meal service at the scheduled meeting following the completion of the tool with recommendations as needed.</p> <p>The date the systemic changes will be completed: June 13, 2014</p>	

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	<p>A Care Plan for Potential for Falls initiated on 03/26/14 identified the following interventions were initiated: "..Assist with toileting every two hours and as needed, education about calling for assist with transfers and reminder sign placed in room, encourage resident to be compliant with limitations and to ask for assistance as needed, ensure proper footwear, evaluate all falls for cause and attempt to prevent further falls, innitiate (sic) appropriate interventions, keep call-light in reach and encourage resident to use it to ask for assistance, notify family and physician all falls...PT/OT (Physical Therapy/Occupational Therapy) to evaluate and treat as needed..."</p> <p>An undated, untimed IDT (Interdisciplinary Team) Progress Note indicated, "On 03/26/14 at 0400 during routine rounds, Res was found lying on floor near bathroom. When questioned stated she was going to the bathroom et (and) did not use call light which was in place. Stated she hit her forehead on the floor...Sustained skin tear...to left hand outer aspect...LFA (left forearm) inner aspect...right hand...Has pull tab alarm that res was carrying when she fell. Educated about using call light for assist to prevent fall. Verbalized understanding. Reminder sign to call for help before getting up placed in room."</p>			

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	<p>A Nurse's note dated 04/02/14 at 1430 (2:30 P.M. indicated, "...A/O (Alert and oriented)...with some confusion. Occasionally tries to get up without assist..."</p> <p>A Nurse's note dated 04/02/14 at 2245 (10:45 P.M.) indicated, "Res. up in bathroom by herself, alarm was in bed. Res. stated she took it off. Educated Res. about alarm and safety..."</p> <p>A Nurse's note dated 04/07/14 at 10:25 A.M. indicated, "A/O...with periods of confusion..."</p> <p>A Nurse's note dated 04/07/14 at 1400 (2:00 P.M.) indicated, "Res. re-educated on safely transferring (sic) expresses understanding..."</p> <p>A Nurse's note dated 04/18/14 at 1915 (7:15 P.M.) indicated, "Res walking around in room unassisted. Alarm was turned off by resident by her own admission...Res bent down and turned alarm back on. This nurse...encouraged to res to use call light for assistance et not to turn off alarms but res c/t's (continues) to be non-compliant with alarms..."</p> <p>An MDS worksheet dated 04/22/14 indicated Resident #100 experienced</p>			

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	<p>moderate cognitive impairment</p> <p>Fall #2: A Nurse's note dated 04/26/14 at 0700 (7:00 A.M.) indicated, "Res. self transferred (sic) to BR (bathroom) ended on floor in Rm (room) Unable to move without pain..."</p> <p>A Nurse's note dated 04/26/14 at 10:30 (A.M./P.M. not specified) indicated, "Res Admitted (to hospital) with fractured right hip."</p> <p>A Nurse note dated 04/26/14 at 1800 (6:00 P.M.) indicated, "Late Entry for 04/25/14 at 1700 (5:00 P.M.) Spoke with resident about safety alarm. Stated, 'I know I need help. I sure don't want to fall.' Assured this nurse that she would con't (continue with safety precautions et always use call light. Alarm removed..."</p> <p>An X-ray report dated 04/26/14 indicated, "...mildly angulated intertrochanter (head of femur) fracture..."</p> <p>A Care Plan for Potential for Falls dated 04/26/14 indicated a new intervention of, "pressure pad alarm at all times for safety..." was initiated.</p> <p>An undated, untimed IDT Progress Note</p>			

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	<p>indicated, "On 04/26/14 at 0700, staff heard a loud noise coming from resident's room. Found resident lying on right on floor near closet...d/t (due to) recent compliance with safety alarm being reported, alarm was removed et remained compliant with using call light for assist...Dtr (daughter) notified...agreed with reporting nurse that res fully understood the safety need to use call light..."</p> <p>A Fall Risk Assessment dated 04/28/14 indicated Resident #100 experienced intermittent confusion and was a high risk to fall.</p> <p>A Nurse's note dated 04/29/14 at 1630 (4:30 P.M.) indicated, "Res. returned to facility ...had right hip fx (fracture)...alert et pleasantly confused..."</p> <p>A Fall Risk Assessment dated 04/29/14 indicated Resident #100 was a high risk to fall.</p> <p>A Rehab Screen dated 04/30/14 indicated Resident #100 experienced a decline in cognition and "...cognitive decline reported..."</p> <p>A Nurse's note dated 05/01/14 at 1545 (3:45 P.M.) indicated, "...Alert with periods of confusion..."</p>			

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	<p>Fall #3:</p> <p>The Nurse's notes from 05/01/14 at 1545 through 05/03/14 at 1945 (7:45 P.M.) lacked any documentation Resident #100 experienced a fall.</p> <p>A Physician's Telephone Order dated 05/03/14 at 1500 (3:00 P.M.) indicated, "Send to ER (Emergency Room) for eval (evaluation)...fall.."</p> <p>A Nurse's note dated 05/03/14 at 1945 indicated, "Res returned to facility from (name of hospital)..."</p> <p>A Fall Risk Assessment dated 05/03/14 indicated Resident #100 was a high risk to fall.</p> <p>An undated, untimed IDT Progress Note indicated, "On 05/03/14 at 1500 (3:00 P.M.) nurse summoned to room by CNA who found res on floor on knees beside bed...recently fell in this facility d/t noncompliance using call light et fractured...hip...stated she was trying to walk from recliner to the other side of the room to answer the telephone. Call light noted to be clipped to recliner...stated she understood what the call light was for. Noted that pressure pad alarm was switched off. Investigation proved that she pulls alarm, clipped on the back of</p>			

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	<p>recliner by the cord toward her to turn off. When questioned about this stated, 'I don't remember.' Pull tab alarm added. Spoke with res about being moved to a room closer to the nurse's station..."</p> <p>A Care Plan for Potential for falls dated 05/03/14 indicated a new intervention of, "Alarms out of reach..." was initiated.</p> <p>A Nurse's note dated 05/05/14 at 1630 (4:30 P.M.) indicated, "Conts (continues to get up unassisted et turns off alarms. Res states she doesn't remember she had call light et that she doesn't know how to use it..."</p> <p>A Nurse's note dated 05/05/14 at 1810 (6:10 P.M.) indicated, "Went to res room et found pressure alarm off again..."</p> <p>An untimed Nurse's note dated 05/06/14 indicated, "...room change..."</p> <p>The Nurse's notes from 05/06/14 through 05/13/14 indicated Resident #100 continued to experience episodes of confusion, but had not disabled the safety equipment and experienced no further falls.</p> <p>A Care Plan for "impaired cognitive r/t (related to) short term memory loss" dated 05/07/14 included, but was not</p>			

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	<p>limited to, "The resident needs supervisions (sic) with all decision making..."</p> <p>During an interview on 05/13/14 at 3:00 P.M., UM (Unit Manager) #1 indicated a fall risk assessment was not done before removing the alarms on 04/25/14 and supervision and/or new interventions were not provided to Resident #100 after the alarm was removed on 04/25/14. UM #1 further indicated at that time, Resident #100's room was located at the far end of the hall from 03/25/14 through 05/06/14 and staff couldn't get to her in time. UM #1 then indicated, Resident #100 experienced no further falls after the resident's room was located closer to the nursing station and the staff was better able to supervise the resident.</p> <p>During an interview on 05/14/14 at 12:45 P.M., the DON (Director of Nursing) indicated Resident #100 was identified as a high risk to fall upon admission to the facility, but no documentation could be provided to indicate safety interventions were implemented before the fall on 03/26/14. The DON further indicated, at that time, Resident #100 experienced intermittent confusion from 03/25/14 through 04/26/14 and only resident education and reminders were initiated after each occurrence of Resident #100</p>			

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F000329 SS=D	<p>successfully disabling the alarms and/or each attempt to transfer independently.</p> <p>A Policy and Procedure for Fall Protocol provided by the DON on 05/14/14 at 12:45 P.M. indicated, "It is the policy of this facility to attempt to prevent injuries to any resident...2. Those resident identified, as high risk will be placed on High Risk Fall Protocol...5. Any resident that has fallen and or made attempt to transfer self with out (sic) assistance will have fall risk Interventions put into place immediately at the time of the fall or attempt..."</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically</p>						

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	<p>contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident receiving anti-psychotic and anti-anxiety medications received effective monitoring for behaviors to support the continued use of these medications in that documentation of behaviors and/or interventions were lacking for 1 of 5 residents reviewed for unnecessary medications. (Resident #45)</p> <p>Findings Include:</p> <p>On 4/7/14 at 11:30 A.M., Resident #45 was observed sitting in the A unit dining room.</p> <p>On 4/13/14 at 1:44 P.M., Resident #45 was observed in his room, lying in his bed.</p> <p>The clinical record for Resident #45 was reviewed on 5/14/14 at 9:40 A.M. Diagnoses included dementia without behavioral disturbance, diabetes type 2, hypertension, and atypical psychosis.</p> <p>The care plans included, but were not limited to, use of psychotropic medication initiated 5/10/12, and resistance to care initiated 2/4/14.</p>	F000329	<p>F329</p> <p>It is the practice of this facility to assure that residents that utilize psychotropic medications are monitored for behaviors with documentation supporting the continued use of the medications.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Resident #45 has documented behavior monitoring in place related to the resident's medication usage.</p> <p><i>Other residents that have the potential to be affected have been identified by:</i></p> <p>All residents that receive psychotropic medications have been reviewed to assure that appropriate documentation is in place related to behavior monitoring.</p> <p><i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p> <p>Nurses have been in-serviced related to assuring that when residents exhibit behaviors that it is documented appropriately. All residents that utilize psychotropic medications are reviewed monthly for possible reduction by the interdisciplinary team. During this review, documentation of behaviors for the resident will be reviewed. If residents have no documented behaviors, the physician will be notified with a request for a</p>	06/13/2014

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	<p>The signed physician's orders included, but were not limited to, Ativan 1mg TID started 7/2/13, and Risperdal 0.25mg TID started on 7/2/13.</p> <p>On 12/26/13 the pharmacy recommended a gradual dose reduction (GDR) be attempted for the Ativan, the physician disagreed with the recommendation and indicated on the form, "the benefits outweigh the risk."</p> <p>On 1/23/14 the pharmacy recommended a GDR be attempted for the rispirdol, the physician disagreed with the recommendation.</p> <p>On 5/14/14 at 2:00 P.M., Resident #45's nursing notes were reviewed with Unit Manager #5 (UM #5). She indicated at that time that behaviors were monitored by tracking them in the nursing notes and by passing them on in the daily clinical meeting. She indicated Resident #45 continued to experience some behaviors usually in the evening, but she confirmed that documentation of behavior disturbances and interventions were lacking for Resident #45.</p> <p>The Social Service Director (SSD) #3 was interviewed on 5/14/14 at 2:50 P.M.</p>		<p>reduction in the medication. The consulting pharmacist, as identified in the 2567, also works with the facility related to psychotropic medication usage with recommendations to the physician.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>A Performance Improvement tool has been established that randomly reviews residents who have orders for psychoactive medications to assure that there is appropriate behavior monitoring documentation to support the use of continued medication usage. This tool will randomly review 5 residents. The Director of Nursing, or designee, will complete the tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools.</p> <p>The date the systemic changes will be completed: June 13, 2014</p>				

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F000431 SS=D	<p>She indicated residents using psychoactive drugs were reviewed monthly by pharmacy and the SSD department. The pharmacy would provide recommendations for adjustments and those recommendations would be sent to the residents' physicians for approval. She indicated staff would track ongoing and new behaviors on a management log located on each unit. SSD #3 indicated she was unable to locate any documentation of recent behavioral concerns and/or physician notification of Resident #45's behaviors. 3.1-48(a)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug</p>			

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	<p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review the facility failed to return and/or dispose of discontinued medications in a timely manner for 1 of 2 medication storage rooms reviewed on the A/B unit in that medication for a discharged resident was kept in the facility past 7 days and the facility failed to store a medication which had a high likelihood of abuse securely behind 2</p>	F000431	<p>F431</p> <p>It is the practice of this facility to assure that all drugs and biologicals are secure and not accessible to residents. It is also the facility practice to assure that medications are disposed of properly when discontinued for any reason.</p> <p><i>The correction action taken for those residents found to be affected by the deficient practice include:</i></p> <p>Residents #194 medication is now securely stored in accordance with</p>	06/13/2014

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	<p>locks in 1 of 2 medication storage rooms reviewed on the E/F unit. (Resident #194, Resident #200)</p> <p>Findings Include:</p> <p>1. On 5/14/14 at 10:48 A.M., an observation of the medication storage room for the A/B unit was completed. During the observation medication was found stored in a cabinet above the sink. Unit Manager #5 (UM #5) indicated these medications belonged to a resident discharged from the facility on 9/2/13. The medication had remained in the facility for 255 days.</p> <p>Bystolic 5mg (an antihypertensive) Isosorbide 30mg (a vasodilator) Nitroglycerin 0.4mg (a vasodilator)</p> <p>2. On 5/14/14 at 11:30 A.M., the medication storage room for the E/F unit was observed with UM #1. During the observation an unopened box of Lorazepam Intensol Oral Concentrate (an antianxiety medication) belonging to Resident #194 was observed sitting on the top shelf of the unlocked refrigerator. During an interview with UM #1, at that time, UM #1 indicated the refrigerator was usually locked, but she did not know currently where the padlock was located.</p>		<p>the regulation. The medication for resident #200 has been appropriately disposed of. Please refer to systems below and means of monitoring.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents have the potential to be affected. The nurses have been in-serviced related to assuring that medications are secure per the regulation and disposed of properly per the regulation. Please refer to systems below and means of monitoring.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>The nurses have been in-serviced related to the importance of assuring that all scheduled II medications as well as medications that are subject to abuse are locked securely in accordance with the regulation The in-service also addresses assuring that medication is disposed of properly and in a timely manner if it is discontinued or the resident discharges from the facility. Nursing administration, via routine rounds will be observing to assure that medications secured appropriately and that medications have been disposed of properly.</p> <p>The corrective action taken to monitor performance to assure compliance through quality</p>	

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	A policy titled "Discontinued Medications" dated April 2007 was provided on 5/14/14 at 11:00 A.M., by UM#1. The policy included "...3. Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies. Within 7 days of order (was hand written by facility)." The policy lacked direction regarding the storage of medications that have a high likelihood of abuse. 3.1-25(r)		assurance is: A Performance Improvement Tool has been initiated that will be utilized to randomly observe medication rooms/carts to assure that medications that have been discontinued have been disposed of properly. In addition, the tool will observe the medication rooms/carts to assure that medications are secured properly in accordance with the regulation. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. The date the systemic changes will be completed: June 13, 2014		

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