

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2014
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NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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F000000	<p>This visit was for the Investigation of Complaints numbered IN00146304 and Complaint IN00146156.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints numbered IN00140622 and IN00140009 completed on 1/2/2014 and Complaint IN00143915 completed on 2/26/14.</p> <p>Complaint number IN00146156: Substantiated, Federal/State deficiencies related to the allegations are cited at F309 and F504.</p> <p>Complaint number IN00146304: Substantiated, No deficiencies related to the allegation are cited.</p> <p>Survey dates: March 25, 26, 27, 2014</p> <p>Facility number: 000314 Provider number: 155478 AIM number: 100274210</p> <p>Survey team: Dorothy Watts, RN TC Terri Walters, RN</p> <p>Census bed type:</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 9 Medicaid: 49 Other: 24 Total: 82</p> <p>Sample: 12</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 1, 2014, by Jodi Meyer, RN</p>				

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F000309 SS=E	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, interview, and record review, the facility failed to ensure residents were monitored for adequate bowel movements (bm) and/or the facility protocol for bowel elimination was followed for 3 of 3 residents reviewed for bowel movements in a sample of 3. Resident X, Resident Y, Resident Z</p> <p>Findings include:</p> <p>1. On 3/26/14 at 11:05 A.M., Resident X's closed clinical record was reviewed. Resident X had been admitted to the facility on 1/25/13 on the secured unit of the facility. Diagnoses included but were limited to, vascular dementia, hypothyroidism, insomnia, and anxiety. Her Minimum Data Set Assessment (MDS) dated 2/12/14, indicated, a cognitive score of 9 (moderate cognitive impairment), extensive assistance of 1 staff needed for toilet use, personal hygiene, and transfers. The MDS</p>	F000309	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on April 1, 2014. F309 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·The resident affected by the alleged deficient of practice resident X has been permanently discharged. Resident Z and Resident Y care plan has been updated and utilizing a bowel elimination policy.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential</p>	04/01/2014			

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	<p>documented "always continent" of bowel and that a bowel toileting program had not been in use. Her February 2014 medication administration record (MAR), did not include bowel medications until Milk of Magnesia (MOM), a laxative had been ordered prn (when needed) daily on 2/12/14, but was not given until 2/28/14.</p> <p>On 3/26/14 at 11:45 A.M., Resident X's bm documentation in the clinical record from 2/1/14 to 3/6/14 were reviewed with the Director of Nursing (DON). On 2/1/14 thru 2/7/14 (7 day period), documentation was lacking of a bm. On 2/8/14, documentation indicated the resident had a large bm. The DON was made aware of documentation lacking of a bm for 7 days. The DON agreed at that time lacking documentation of a bm for 7 days was a problem.</p> <p>On 3/26/14 at 11:45 A.M., documentation indicated no bms on 2/25/14, 2/26/14, 2/27/14, and 2/28/14. The MAR documented MOM (a laxative) had been given on 2/28/14. The MAR lacked documentation of results of the prn (when needed) MOM given on 2/28/14. The first dose since the physician's order had been received</p>		<p>to be affected by the alleged deficient practice. DNS/Nurse managers /Designee performed a bowel assessment on every current resident and new admissions and address any concerns per protocol. ·MDS coordinator/designee has reviewed all residents care plans to ensure monitoring was provided per plan of care regarding at risk for constipation and will assess each new resident and create care plan for at risk for constipation. ·DNS/Licensed Nurse/Designee will perform a daily audit of bowel management report. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ·Education on bowel management/tracking has been provided to nursing staff by DNS/DNSS/Designee by April 1, 2014 ·Documentation review will be conducted by DNS/Designee daily and be performed by DNS/nurse managers/designee to ensure monitoring of residents with bowel elimination according to care plan and any issues will be immediately reported to ED/DNS/Nurse manager /Designee for appropriate follow up. ·Staff will utilize bowel elimination policy to ensure residents are monitored</p>				

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	<p>on 2/12/14. A bowel protocol(MAR) for Resident X dated 3/1/14 thru 3/31/14, indicated MOM 30 ml had been given on day shift 3/1/14 and a dulcolax suppository 10 mg had been given on 3/1/14 on 2nd shift. The clinical record had documentation of 2 small bms on 3/2/14. The DON indicated the facility bowel protocol had been initiated on 3/1/14 in the facility. The policy included if no bm in 2 days start the bowel protocol on the 3 rd day. Give MOM 30 ml orally on the 1st shift, if no bm. If no bm by the 2nd shift then administer a dulcolax suppository 10 mg (rectally). If no bm by 3rd shift, give an enema (rectally). If no bm after the enema the physician should be notified.</p> <p>On 3/26/14 at 11:55 A.M., the DON, explained the facility bowel protocol. She indicated if no bms in 2 days, on 3 rd day- day shift the nurse administers MOM, and then if no bm on 3rd day- 2nd shift (evenings), the nurse gives a dulcolax suppository, and if no bm on 3rd shift, the nurse administers an enema. The policy indicated if no bm after the enema, the physician was to be notified. Resident X had the bowel protocol sheet (dated 3/1/14 to 3/31/14) included in the clinical record with her March 2014 MAR.</p>		<p>according to care plan.</p> <ul style="list-style-type: none"> ·DNS/Charge nurse/designee daily will conduct rounds to ensure residents are monitored per plan of care. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·DNS/Nurse managers/Designee will round daily using bowel elimination CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place according to care plans. ·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in quality assurance meeting every month for a minimum of 6 months. <p>Compliance date: April, 1 2014</p>				

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	<p>On 3/26/14 at 2:50 P.M., the secured unit Nurse Manager (unit Resident X had resided) was interviewed regarding the facility bowel protocol. She indicated the facility had a bowel protocol that had been initiated recently but she didn't know the initiation date. She indicated before the new protocol, her normal practice had been to give a laxative to the resident after the 3rd day without a bm.</p> <p>2. On 3/26/14 at 11:10 A.M., Resident Z's clinical record was reviewed. He had been admitted to the facility on 7/10/13. Diagnoses included but were not limited to, dementia with behaviors and IED (Intermittent Explosive Disorder). His Minimum Data Set Assessment (MDS) dated 1/12/14, indicated a cognitive score of 3 (severe cognitive impairment), and extensive assistance of 1 staff for toilet use. The MDS also indicated frequently incontinent of bowel and that the resident had been on a bowel toileting program.</p> <p>On 3/26/14 at 3:10 P.M., Resident Z's bm documentation from 2/1/14 to 3/25/14 was reviewed with the</p>						

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	<p>secured unit Nurse Manager. Documentation was lacking of a bm for 5 days from 3/20/14 thru 3/24/14. The clinical record indicated the bowel protocol (initiated 3/1/14) of MOM had not been initiated until 3/24/14 at 7:00 P.M., on the 5th day not the 3rd day as the facility protocol instructed. The secured unit Nurse Manager indicated the MOM had not been given timely. She indicated the resident should have been given the MOM on 3/22/14 per protocol the 3rd day (without a bm) as the facility protocol instructed.</p> <p>3. On 3/26/14 at 11:30 A.M., Resident Y's clinical record was reviewed. Her Minimum Data Set Assessment (MDS) dated 2/5/14, indicated a cognitive score of 3 (severe cognitive impairment), and extensive assistance of 1 staff for transfers and toileting. Bowel continence was documented as frequently incontinent and that the resident was on a bowel toileting program. On 3/26/14 at 3:05 P.M., Resident Y's bm documentation from 2/1/14 to 3/24/14 was reviewed with the secured unit Nurse Manager. Resident Y had the facility bm protocol dated 3/1/14 with her March 2014 MAR. Documentation was lacking of a bm from 3/1/14 to 3/4/14</p>						

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	<p>(4 days). Documentation was also lacking of a bm from 3/19/14 to 3/23/14 (5 days). The secured unit Nurse Manager indicated no bm protocol had been initiated (prn medications) for the 4 and 5 day periods without a bm. She indicated the protocol should have been started per protocol on the 3rd day (day shift) after 2 days with no bm.</p> <p>On 3/27/14 at 4:10 P.M., Resident X's January 2014 bm documentation was reviewed with the DON, Administrator, and the RN Consultant. Staff was made aware of no bms documented from 1/28/14 to 1/31/14 and continued from 2/1/14 to 2/7/14- an 11 day period. Review of January medication orders indicated no laxatives or suppositories were ordered until 2/12/14. The DON indicated the facility bowel protocol had not been followed. The DON and the RN Consultant indicated the facility bowel protocol initiated 3/1/14 was being discontinued today. They indicated the facility was initiating a bowel elimination action plan and nursing staff would be inserviced.</p> <p>This Federal tag relates to Complaint IN00146156</p> <p>3.1-37(a)</p>						

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F000504 SS=D	<p>483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN</p> <p>The facility must provide or obtain laboratory services only when ordered by the attending physician.</p> <p>Based on observation, interview and record review the facility failed to ensure that a laboratory test which was ordered by a physician was completed for 1 of 3 residents reviewed for urinary tract infections. Resident Y</p> <p>Findings include:</p> <p>Resident Y was observed on 2/27/14 at 1:25 P.M., being assisted to the bathroom and was toileted by CNA #1.</p> <p>Clinical Records for Resident Y were reviewed on 3/26/14 at 2:30 P.M. The admission date for Resident Y was 4/6/14. Medical diagnoses included, but were not limited to, depression, urinary tract infection, psychosis, incontinence.</p> <p>The most recent Quarterly MDS (Minimum Data Set Assessment) dated 12/10/13 indicated Resident Y had severely impaired cognition and required the assistance of one staff for toileting.</p>	F000504	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on or after April 1, 2014. F504 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The resident affected by the alleged deficient practice has had urine analysis and culture and sensitivity completed as per physician order verified by IDT according to the physician order policy. · DNS/ADNS/Designee/IDT will review and check compliance with the following physician orders policy. All Physician orders will be reviewed in clinical meeting for completeness, and legibility, during morning rounds with the floor nurses and against the MAR's, TAR's, and Lab tracking log daily to ensure orders were transcribed accurately. How</p>	04/01/2014	

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	<p>A lab result document was faxed to the MD by the facility on 3/19/14 at 3:10 P.M., and a return fax from the doctor was received at 7:00 P.M., and it read as follows, "Need C and S (culture and Sensitivity) (A laboratory test to determine which antibiotic would be most effective in killing the bacteria identified in the urine sample) Septra DS 1 Bid x 10 days"</p> <p>The Medication administration Record dated 3/2014 read as follows, "Septra DS 1 BID X 10 days"</p> <p>A Physician order for 3/18/14 read as follows: ' UA for possible UTI" A Physician order for 3/19/14 read as follows: "Septra DS 1 BID X 10 days UTI"</p> <p>The policy and procedure for Compliance with Physician's Orders was provided by the HCA and reviewed on 3/27/14, and it read as follows, "...Telephone orders are received only by a licensed nurse or licensed pharmacist and are immediately reduced into writing in the resident chart."</p> <p>During an interview with the Secured Unit Manager (SUM) and the Health Care Administrator on 3/27/14 at 9:25</p>		<p>will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> · All residents have the potential to be affected by the alleged deficient practice. · DNS/Nurse managers/Designee have reviewed MAR's, TAR's, and Lab tracking log daily to ensure labs are obtained per physician order. · All licensed nurses have been re-educated by DNS/DNSS/Designee on writing and transcribing orders accurately. Education completed by April 1, 2014. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · DNS/Nurse managers/Designee will review MAR's, TAR's, and Lab tracking log daily to ensure labs are obtained per physician order. · All Physician orders will be reviewed in clinical meeting for completeness, and legibility, during gemba with the floor nurses and against the MAR's, TAR's, and Lab log daily to ensure orders were transcribed accurately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? 				

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	<p>A.M., the SUM indicated the physician ordered a culture and sensitivity test on 3/19/14. The SUM further indicated it would take 3 days for the lab results to be returned to the facility. The SUM indicated she called the Lab facility and no culture and sensitivity test had been completed on Resident Y's urine sample.</p> <p>This Federal tag relates to Complaint IN00146156.</p> <p>3.1-49(f)(1)</p>		<p>·DNS/Nurse managers/Designee will round daily using the physician order CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure physician orders are followed accurately.</p> <p>·If a threshold of 100% is not achieved an action plan will be developed. Findings will be reported in quality assurance meeting every month for a minimum of 6 months.</p> <p>Compliance date: April 1, 2014</p>		