STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155166		07/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALPARAISO CARE AND REHABILITATION CENTER	606 WALL ST VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00127272, IN00128392, and IN00131198. Complaint IN00127272 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00128392 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00131198-Substantiated, Federal/Sate deficiencies related to the allegation are cited at F312. Survey dates: July 8, 9, 10, 11, 12, 15, 16, 2013 Facility number: 000083 Provider number: 155166 AIM number: 100289670 Survey team: Shannon Pietraszewski, RN-TC Jennifer Redlin, RN Yolanda Love, RN Janelyn Kulik, RN (July 8th) Regina Sanders, RN (July 9th and 10th)	F000000	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. Thisprovider respectfully requests that the 2567 Plan of Correction be consideredthe Letter of Credible Allegation and requests a post survey desk review on orafter August 15, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Census bed type: SNF/NF: 136 Total: 136 Census Payor type: Medicare: 9 Medicaid: 113 Other: 14 Total: 136 There deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on July 22, 2013, by Janelyn Kulik, RN.			

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F000250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure social services were managing and monitoring behaviors for 2 of 3 residents with behaviors in a sample of 10. The facility also failed to ensure social services followed up on a Prior Authorization for a resident in need of new dentures for 1 of 40 residents reviewed for dental services. (Resident #90, #91 and #195) Finding included: 1. Resident #90's record was reviewed on 7/12/13 at 10:38 a.m. Resident #90's diagnoses included, but were not limited to, depressive disorder, lesions, cardiac pacemaker, dementia with behavior disturbance/senile delirium, hyperlipidemia, chronic total occlusion coronary artery, Alzheimer's, hypertension, muscle weakness, stroke, and diabetes. Resident #90 was admitted to the facility 3/16/12. The Return/Discharge MDS	F000250	**F250 PROVISION OFMEDICALLY RELATED SOCIAL SERVICE** Thefacility must provide medically-related social services to attain or maintainthe highest practicable physical, mental, and psychosocial well-being of eachresident. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□□Resident #90's Social Service Behavior Monthly Summary forms and careplans have been reviewed and updated as indicated. •□□□□□□□Resident #195 was placed on Behavior monitoring and the care plan wasupdated as indicated. •□□□□□□□Prior authorization was resubmitted for Resident #91's denturereplacement by the dentist. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand**	08/15/2013

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	(Minimum Data Set) Assessment dated 5/24/13, indicated the resident was severely cognitively impaired and the resident had no moods or behaviors. A SSBMS (Social Service Behavior Monthly Summary) form for June, 2013, was completed by Social Service on 7/11/13. The form indicated the resident was being monitored for paranoid thinking, yelling/cursing at, and threatening staff and insulting "African American" staff. The medications indicated the resident was receiving Paxil (antidepressant) 40 mg (milligrams) daily, Seroquel (antipsychotic) 50 mg twice a day and 100 mg every night, Ativan (anti-anxiety)1 mg prn (as needed) every 6 hours for behaviors. Review of the July 2013 MAR (Medication Administration Record), indicated the order for Paxil and Ativan had been discontinued and there was a new order for Zoloft (antidepressant). An interview with the Unit Manager of the Cottage on 7/12/13 at 1:40 p.m., indicated the resident did not currently have an order for prn (as needed) Ativan.		**what corrective action will be taken** •□□□□□□□All residents have the potential to be affectedby the alleged deficient practice. •□□□□□□□Care Plans for all residents who currently are on the behaviormanagement program have been reviewed by the Interdisciplinary Team foraccuracy and updated as indicated. •□□□□□□□Dental prior authorization requests will be logged on a PriorAuthorization Request Log and monitored weekly until the authorization ordenial is received. •□□□□□□□The Prior Authorization Log will be reviewed by the Social ServiceDirector weekly to ensure timely follow through with prior authorization withthe dentist. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •□□□□□□□Dental prior authorization requests will be logged on a PriorAuthorization Request Log and monitored weekly until the authorization ordenial is received. •□□□□□□□The Interdisciplinary Team will review the physician orders at the clinicalmeeting (Mon-Fri) for all admissions and readmissions for behaviors and	

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	An interview with SSA (Social Service Assistant) on 7/12/13 at 1:41 p.m., indicated the resident was discharged from the facility on 5/24/13 and returned to the facility on 6/3/13. SSA indicated she did not look at the resident's chart for new orders when he returned to the facility nor did she review the chart before completing his June SSBMS form. SSA indicated she did not realize the resident's medications had been changed. SSA indicated the June SSBMS form and the care plans were not updated with the new medications and also indicated there was a data error in relation to her documentation of the Seroquel. 2. Resident #195's clinical record was reviewed on 7/15/13 at 1:00 p.m. Resident #195's diagnoses included, but were not limited to, anxiety, chest pain, depressive disorder, atrial fibrillation, pacemaker, acute myocardial infarction (heart attack), dementia with behavior disturbance, and Alzheimer's, and suicidal ideation. The resident was first admitted to the facility on 4/8/13. The resident was readmitted on 6/24/13. A Behavior Event form dated 6/11/13, indicated the resident was observed		orbehavior management plan. •The DNS/designee is contacted duringweekends/holidays for any new or worsening behavior for implementation of aBehavior intervention. •The Interdisciplinary Team will review careplans for all admissions and readmissions for Behavior Plans during clinicalmeeting (Mon-Fri) and update as indicated. •The Interdisciplinary Team will be educatedon Admission/Readmission procedures, Care Plan updating, the BehaviorManagement Program and Prior Authorization process by the SDC/designee by7/30/13. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •The Social Service Director/designee will complete the "Admission/ReadmissionProcedure", "Behavior Management", "Dental Services" CQI audit tools weekly x 4weeks, the monthly ongoing thereafter for at least 6 months. •If a threshold of 95% is not met an action plan will be created.	

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	with staff sitting in the lounge drinking coffee and participating in activities, the resident came over to the nursing station and stated, "I want the hell out of here!" The resident walked over to the fire extinguisher, grabbed it off the wall and hit the entry door with it. After the fire extinguisher was removed from the resident, she was brought to a quiet area and was allowed to vent her feelings. The resident was placed on 1:1 and the resident began yelling about her daughter. A call was placed to the resident's physician and new orders were received to transfer the resident to a psychiatric hospital for an evaluation and treatment. The daughter was also notified. The daughter indicated the resident had been treated at the stress center before for her behaviors. A history and physical exam dated 6/12/13, indicated the facility had reported the resident was trying to elope. The resident showed no remorse for smashing the window and indicated she would do it again. The impression and plan indicated vascular dementia with delusions, dementia with behaviors including physical violence, and depression with a history of suicidal ideation.		•□□□□□□The MDS Coordinator/designee will complete the “Care Plan Updating” CQItool weekly x 4 weeks, the monthly ongoing thereafter for at least 6 months. •□□□□□□Data will be submitted to the CQI Committeefor review and follow up. •□□□□□□Noncompliance with facility procedures mayresult in disciplinary action	

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	A Psychiatric Evaluation dated 6/18/13, indicated the resident was previously hospitalized prior to her admission into the facility on April 8, 2013, due to agitation, confusion, and suicidal threats. The evaluation indicated the hospital staff was informed by the daughter of the resident's past threats to attack her "countless times" at home. The Quarterly MDS Assessment dated 7/10/13, indicated the resident was severely cognitively impaired. The MDS also indicated the resident had no moods or behaviors. An interview with the Unit Manager of the Cottage on 7/15/13 at 1:45 p.m., indicated there was no documentation for behavior monitoring since the resident's readmission on 6/24/13. The Unit Manager also indicated the SSBMS forms were not completed. An interview with Unit Manager #2 on 7/15/13 at 2:30 p.m., indicated the resident should have been monitored for behaviors when she returned from the hospital in June. An interview with SSA (Social Service Assistant) on 7/15/13 at 2:35 p.m., indicated there were no care plans or behavior monitoring logs when the			

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	resident was admitted on April 8, 2013, and there were no care plans or behavior monitoring logs when the resident returned from the psychiatric hospital on June 24, 2013. The Behavior Management Policy and Procedure (undated) was provided by the DNS (Director of Nursing Services) on 7/15/13 at 2:50 p.m. The policy indicated it was the policy of the facility to provide behavior interventions and monitoring for residents with problematic or distressing behaviors. Care plans should be initiated for the behavioral symptoms related to psychotropic medication use and its associated diagnoses. New or worsening behaviors were to be reviewed by the IDT (Interdisciplinary Team). Interventions and behaviors were to be changed on the care plan, behavior monitoring record, or the CNA assignment sheet if applicable. All behaviors were to be reviewed monthly. 3. An interview with Resident #91 on 7/9/13 at 12:04 p.m., indicated he had broken dentures. The lower denture was observed to be loose fitting only. Resident #91's clinical record was reviewed on 7/11/13 at 11:20 a.m. Resident #91's diagnoses included,			

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	but were not limited to, depression, aphasia (difficulty speaking) and CVA (stroke). An Admission MDS (Minimum Data Set) Assessment dated 11/24/12, indicated Resident #91 had broken or loosely fitting full or partial denture and no natural teeth or tooth fragment. A care plan initiated on 11/27/12, indicated the resident wore dentures. The care plan indicated the resident reported the upper and lower dentures had not fit well for 10 years. The interventions indicated to assist the resident with oral care routinely, dental consult as indicated, observe and document gum problems, observe for decreased ability to chew food, therapy screen quarterly and as needed. A Social Service note dated 2/6/13, indicated the resident had been seen by the dentist. No recommendations were made during the visit. A Dental Note dated 2/15/13, indicated the resident needed a Prior Authorization (PA) with Medicaid for denture replacement. The note indicated the resident had the dentures for 15 plus years.			

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	A Social Service note dated 2/18/13, indicated the resident had been seen by a dentist on 2/15/13. The note indicated the resident had "ill fitting dentures" that were more than 15 years old. The note indicated the dentist was to send in the PA (Prior Authorization) for new dentures. There was no further documentation or follow up by Social Service regarding the PA for the dentures. An interview with the SSD (Social Service Director) on 7/12/13 at 1:15 p.m., indicated she did not know if the PA had been approved. The SSD indicated the dental office was responsible for following up with the PA approval. The SSD indicated a PA would generally takes approximately two months for approval. The SSD indicated when a PA came through, she would talk with the resident and/or family regarding any deviation for payment. The SSD indicated she did not know if she or her assistant, would follow up with dentist after not hearing anything for two months. An interview with the SDD 7/16/13 at 1:45 p.m., indicated the dental office had not heard back from Medicaid on			

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	the PA, but she "could" request for them to resubmit another PA. A Dental Service Policy dated January, 2006, was provided by the DNS (Director of Nursing Services) on 7/15/13 at 2:50 p.m. The policy indicated "The facility maintains an outside resource to provide dental services to meet the needs of each resident...Residents with lost, poorly fitting, or damaged dentures are promptly referred to the dentist..." 3.1-34(a)			

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F000279 SS=D	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. 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. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on interview and record review, the facility failed to properly develop comprehensive care plans related to behavior management for 1 of 48 residents who met the criteria for care plans. (Resident #195) Finding included: Resident #195's clinical record was reviewed on 7/15/13 at 1:00 p.m. Resident #195's diagnoses included, but were not limited to, anxiety, chest pain, depressive disorder, atrial fibrillation, pacemaker, acute	F000279	**F279 DEVELOP COMPHRENSIV E CARE PLANS** A facility must use theresults of the assessment to develop, review and revise the resident'scomprehensive plan of care. The facility must develop acomprehensive care plan for each resident that includes	08/15/2013

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	myocardial infarction (heart attack), dementia with behavior disturbance, and Alzheimer's, and suicidal ideation. The resident was first admitted on 4/8/13. The resident was readmitted to the facility on 6/24/13. A Behavior Event form dated 6/11/13, indicated the resident was observed with staff sitting in the lounge drinking coffee and participating in activities, the resident came over to the nursing station and stated, "I want the hell out of here!" The resident walked over to the fire extinguisher, grabbed it off the wall and hit the entry door with it. After the fire extinguisher was removed from the resident, she was brought to a quiet area and was allowed to vent her feelings. The resident was placed on 1:1 and the resident began yelling about her daughter. A call was placed to the resident's physician and new orders were received to transfer the resident to a psychiatric hospital for an evaluation and treatment. The daughter was also notified. The daughter indicated the resident had been treated at the stress center before for her behaviors. A history and physical exam dated 6/12/13, indicated the facility had reported the resident was trying to		measureable objectivesand timetables to meet a resident's medical, nursing, and mental andpsychosocial needs that are identified in the comprehensive assessment. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□□Resident #195 was placed on Behavior monitoring and the care plan wasupdated as indicated. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken** •□□□□□□□All residents have the potential to beaffected by the alleged deficient practice. •□□□□□□□Care Plans for all residents who currently are on the behaviormanagement program have been reviewed by the Interdisciplinary team for accuracy and updated as indicated. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not**	

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	elope. The resident showed no remorse for smashing the window and indicated she would do it again. The impression and plan indicated vascular dementia with delusions, dementia with behaviors including physical violence, and depression with a history of suicidal ideation. A Psychiatric Evaluation dated 6/18/13, indicated the resident was previously hospitalized prior to her admission into the facility on April 8, 2013, due to agitation, confusion, and suicidal threats. The evaluation indicated the hospital staff was informed by the daughter of the resident's past threats to attack her "countless times" at home. An interview with SSA (Social Service Assistant) on 7/15/13 at 2:35 p.m., indicated there were no care plans for behavior monitoring when the resident was admitted on April 8, 2013, and there were no care plans when the resident returned from the psychiatric hospital on June 24, 2013. The Behavior Management Policy and Procedure (undated) was provided by the DNS (Director of Nursing Services) on 7/15/13 at 2:50 p.m. The policy indicated it was the policy of the facility to provide		**recur** •The Interdisciplinary Team will review care plansfor all admissions and readmissions during clinical meeting (Mon-Fri) andupdate as indicated. •The Interdisciplinary Team will review the physician orders at the clinicalmeeting (Mon-Fri) for all admissions and readmissions for behaviors and or behaviormanagement plan. •The DNS/designee is contacted duringweekends/holidays for any new or worsening behavior for implementation of aBehavior intervention. •The Interdisciplinary Team will be educatedon Admission/Readmission procedures, Care Plan updating and Behavior Management by the SDC/designee by 7/30/13. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •The Social Service Director/designee will complete the "Admission/ReadmissionProcedure", "Behavior Management" CQI audit tool weekly x 4 weeks, the monthlyongoing thereafter for at	

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	behavior interventions and monitoring for residents with problematic or distressing behaviors. Care plans should be initiated for the behavioral symptoms related to psychotropic medication use and its associated diagnoses. New or worsening behaviors were to be reviewed by the IDT (Interdisciplinary Team). Interventions and behaviors were to be changed on the care plan, behavior monitoring record, or the CNA assignment sheet if applicable. All behaviors were to be reviewed monthly. 3.1-35(c)(1)		least 6 months. •□□□□□□If a threshold of 95% is not met an action plan will be created. •□□□□□□The MDS Coordinator/designee will complete the “Care Plan Updating” CQItool weekly x 4 weeks, the monthly ongoing thereafter. •□□□□□□Data will be submitted to the CQI Committeefor review and follow up. •□□□□□□Noncompliance with facility procedures mayresult in disciplinary action	

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F000309 SS=D	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. Based on record review and interview, the facility failed to properly assess and monitor resident's perma catheter. This affected 1 of 1 resident who met the criteria for perma catheters. (Resident # 185) Findings included: Resident #185's clinical record was reviewed on 7/10/13 at 10:10 a.m. Resident #185's diagnoses included, but were not limited to pacemaker, muscle weakness, malnutrition, convulsions, enteritis, shortness of breath, hypertension, end stage renal disease, atrial fibrillation, dialysis, anemia, and pleural effusion. The resident was admitted to the facility on 3/15/13. A care plan was initiated on 3/18/13 for potential complications related to dialysis. The interventions indicated to assess the right perma catheter every shift, monitor weights, and observe fluid/food intake.	F000309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING** Each resident must receive and the facility must providethe necessary care and services to attain or maintain the highest practicablephysical, mental, and psychosocial well-being, in accordance with thecomprehensive assessment and plan of care. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□An assessment was completed for Resident #185's perma catheter beforeand after each dialysis center visit.	08/15/2013

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	Review of the May, June and July 2013 MAR (Medication Administration Record)/TAR (Treatment Administration Record), with a starting date of 4/4/13, indicated to "access [sic] site right chest check dressing site daily port a cath [sic]". FYI (for your information) was indicated and not every shift. There was no documentation indicating the resident's perma catheter was assessed daily. An interview with the East Wing Unit Manager on 7/10/13 at 10:33 a.m., indicated residents with perma catheters were to be assessed before and after dialysis appointments. An interview with LPN #7 on 7/11/13 at 1:29 p.m., indicated the physician order with "FYI", was an alert to the staff which allowed them to contact the dialysis center and the physician when there was a need to report changes in the site. She also indicated when residents leave for treatment, she would assess the perma catheters and obtain a full set of vitals. Upon their return, she would obtain a second set of vitals and assess the catheter site for bleeding, and document it in the computer.		**How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken** •□□□□□□All residents with a perma catheter have the potential to be affected by thealleged deficient practice. •□□□□□□Nurses will be educated on Dialysis CarePolicy by the SDC/designee by 7/30/13. •□□□□□□All residents with a perma catheter site havebeen assessed. Care Plans have beenupdated to ensure perma catheter sites are assessed pre/post dialysis. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •□□□□□Unit Manager/designee will audit the DialysisFlow Sheet daily in clinical meeting (Mon-Fri) to ensure that there isdocumentation that the access site has been assessed. •□□□□□The nursing manager will audit the DialysisFlow Sheet on Saturday to ensure that there is documentation that the accesssite has been assessed. •□□□□□□Nurses will be educated	

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	An interview with LPN #7 on 7/12/13 at 10:20 a.m., indicated there were no documentation of the perma catheter being assessed every shift since the resident admission on 3/15/13. A Dialysis Care policy dated 9/2012, was provided by the DNS on 7/12/13 at 10:00 a.m. The policy indicated "...An assessment of the resident's dialysis access site will be completed daily to include bruit and thrill if applicable, condition of skin at site, drainage, pain, warmth, redness, and record on the MAR and/or dialysis flow sheet specific to facility policy." An assessment of the resident will be completed upon return from each dialysis visit to include vital signs and assessment of the site. Documentation of the assessment would be recorded in the computer and dialysis flow sheet or MAR. 3.1-37 (a)		on Dialysis CarePolicy by the SDC/designee by 7/30/13. •□□□□□□□Nurses during nursing rounds, per shiftdaily, will check all residents with a perma catheter to ensure that there isdocumentation the perma catheter access site has been assessed pre/postdialysis. Findings will be documented on the Daily Nursing Rounds Checklist andaddressed immediately. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •□□□□□□□The Unit Managers will complete the “DialysisCare” CQI tool will be utilized weekly x 4, then monthly ongoing thereafter forat least 6 months. •□□□□□□□If a threshold of 95% is not met an action plan will be created. •□□□□□□□Data will be submitted to the CQI Committeefor review and follow up. •□□□□□□□Noncompliance with facility procedures mayresult in disciplinary action.	

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F000312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. Based on observation, record review and interview, the facility failed to ensure dependent residents receive necessary services to maintain good grooming and oral hygiene for 2 of 7 reviewed for ADL's (Activities of Daily Living). (Resident #151 and #202). Findings included: 1. On 7/10/13 at 11:00 a.m., Resident #151 was observed with long fingernails and his hands were contracted shut. The resident was observed in bed wearing a gown. On 7/10/13 at 3:00 p.m., Resident #151 was observed to be in bed wearing a gown. On 7/11/13 at 9:00 a.m., Resident #151 was observed with long fingernails and his hands were contracted shut. The resident was observed in bed wearing a gown. On 7/12/13 at 3:00 p.m. Resident #151 was observed to be in bed	F000312	**F312 ADL CARE PROVIDED FORDEPENDENT RESIDENTS** Aresident who is unable to carry out activities of daily living received thenecessary services to maintain good nutrition, grooming, and personal and oralhygiene. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□□Resident #151 has received oral and nail careand continues to received ADL care regular and routinely. •□□□□□□□Resident #202 has received ADL care andcontinues to receive ADL care regular and routinely. •□□□□□□□Resident #151 and #202 are care planned towear gown per resident preference. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be**	08/15/2013

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	wearing a gown. On on 7/15/13 at 10:00 a.m., Resident #151 was observed with fingernails trimmed slightly, dry, flaky lips and white, thick substance in his oral cavity. During this time, an interview with LPN #3 indicated mouth care was to be done on the ventilator residents every two hours and was not aware when the resident had his last oral care. Resident #151's clinical record was reviewed on 7/10/13 at 11:00 a.m. Resident #151's diagnoses included, but were not limited to, anxiety disorder, pulmonary embolism (clot in the lungs), cardiomyopathy (enlarged heart), congestive heart failure, respiratory failure/ventilator dependent, quadriplegic, and CVA (stroke). A care plan dated on 12/22/11, indicated the resident was dependent for ADL's (Activities of Daily Living) related to diagnosis of CVA (stroke) and quadriplegia. The interventions indicated on 12/8/12, to assess the resident through out the day for hygiene needs, assist with all ADL's, observe for and assistance with pain relief, and therapies as ordered/required.		**taken** •□□□□□□□All residents have the potential to beaffected by the alleged deficient practice. •□□□□□□□The Unit Managers completed rounds to identify other residents thatrequired personal hygiene services. Areas that were identified were immediately addressed. •□□□□□□□All staff will be educated on ADL care by the SDC/designee by 7/30/13. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •□□□□□□□During Customer Care rounds (Monday –Friday), as well as nursing rounds per shift daily all residents will bereviewed for ADL care. Findings will be documented on the NursingRounds Checklist and the Customer Care Rounds Sheets and will be addressedimmediately. •□□□□□□□Unit Managersmonitor resident care by making rounds on their units. Concerns are addressed with the nursing aide,as needed. •□□□□□□□The Director of Nursing Services is responsibleto monitor for facility compliance and reviews the Nursing Rounds	

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	A care plan dated on 3/6/12, indicated the resident liked to be awake and cleaned up. A quarterly MDS (Minimum Data Set) Assessment dated 5/6/13, indicated the resident was cognitively intact and the resident was totally dependent for ADL's. A Resident Care/Need Sheet reviewed on 7/12/13 at 2:35 p.m., indicated the resident was to receive showers every Monday and Friday on the 6:00 a.m. to 2:00 p.m. shift. Review of the shower sheets dated 7/1/13, 7/5/13, 7/8/13, and 7/12/13, did not indicate if nail care was done and nail care was not an option on the sheet. Interview with the West Wing Unit Manager on 7/12/13 at 2:30 p.m., indicated the nursing staff was responsible to make sure nail care had been done for the residents and oral care was to be provided every shift. An interview with Resident #151's spouse on 7/15/13 at 3:00 p.m., indicated she had to clean the resident's mouth frequently when she		Checklistsdaily (Mon-Fri). •□□□□□□□The Customer Care Rounds Sheets will bereviewed during daily meetings by the ED/designee for compliance. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •□□□□□□□The Unit Managers/designee will complete the "Accommodation of Needs"CQI Tool weekly x 4 weeks and then monthly ongoing thereafter for at least 6 months. •□□□□□□□If a threshold of 95% is not met an action plan will be created. •□□□□□□□Data will be submitted to the CQI Committeefor review and follow up. •□□□□□□□Noncompliance with facility procedures mayresult in disciplinary action	

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	visits. She had indicated the resident received poor oral care. 2. On 7/10/13 at 11:00 a.m., Resident #202 was observed to be in bed wearing a gown. On 7/12/13 at 2:50 p.m., the resident was observed up in her chair with street clothes on, and her hair had not been combed. On 7/15/13 at 11:30 a.m.,the resident was observed in bed and shook head no if she had a shower since being out of isolation. Her nails were long, jagged and appeared unkept with dark substance under the nails, and her hair was not combed. On 7/15/13 at 1:50 p.m., the resident was observed in bed with her hair straight up. The resident's fingernails continued to be long, jagged, and unkept. Resident #202's clinical record was reviewed on 7/11/13 at 1:40 p.m. Resident #202's diagnoses included, but were not limited to, anemia, hypertension, and respiratory failure/ventilator dependent. A care plan dated 6/13/13, indicated the resident was dependent with			

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	ADL's (Activities of Daily Living) due to impaired mobility/vision/cognition. The interventions indicated to provide oral care at least two times daily, provide showers two times per week and partial bath in between showers. The Social Service Admission Assessment note dated 6/18/13, indicated the resident was non-verbal and unresponsive and staff had to anticipate all of the resident's needs. Review of the shower sheets dated 7/3/13, 7/6/13, 7/10/13 and 7/13/13, indicated the resident had a complete bed bath but no nail care was indicated. Review of the Resident Care/Need Sheet reviewed on 7/12/13 at 2:35 p.m., indicated the resident received showers on Wednesday & Saturday on 6:00 a.m. to 2:00 p.m. shift and the sheet also indicated the resident was a diabetic Interview with the West Wing Unit Manager on 7/12/13 at 2:30 p.m., indicated the resident would notify staff when she was ready to get up out of bed, the resident had been in droplet isolation since her admission and was just recently removed from isolation. The Unit Manager also			

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	indicated the nursing staff was responsible to make sure nail care had been done for the residents. A facility policy for ADL care was requested but not provided. This Federal Tag relates to complaint number IN00131198. 3.1-38(a)(3)(B) 3.1-38(a)(3)(D)			

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F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to ensure a resident was properly assessed for an indwelling catheter in relation to a diagnosis for 1 of 1 resident reviewed. (Resident #185) Findings Include: Resident #185 was observed with a foley catheter on 7/9/13 at 3:10 p.m. Resident #185's clinical record was reviewed on 7/10/13 at 11:30 a.m. Resident #185's diagnosis included, but were not limited to, End Stage Renal Disease. A Comprehensive MDS (Minimum Data Set) Assessment dated 3/26/13, indicated the resident has an indwelling foley catheter, no pain, and had three unstageable pressure	F000315	**F315 NO CATHETER, PREVENT UTI, RESTOREBLADDER** Based on the resident'scomprehensive assessment, the facility mustensure that a resident who enters thefacility without an indwelling catheter is not catheterized unlessthe resident's clinical condition demonstrates that catheterization wasnecessary; and a resident who is incontinent of bladder receives appropriate treatment and services toprevent urinary tract infections and to restore as much normal bladder functionas possible. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice**	08/15/2013

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	ulcers. A Significant Change MDS Assessment dated 4/11/13, indicated the resident had an indwelling foley catheter, no pain, and 2 unstageable pressure ulcers. A physician order dated 4/14/13 indicated the diagnoses for the foley catheter was pain. A Significant Change MDS Assessment dated 5/21/13, indicated the resident had an indwelling foley catheter, frequent pain rated at severe, and no pressure ulcers. A 14 day MDS Assessment dated 6/23/13, indicated the resident had an indwelling foley catheter, no pain, and no pressure ulcers. An interview with the resident on 7/11/13 at 2:36 p.m., indicated the catheter was placed during a hospital stay. The resident indicated she had discomfort while urinating, however, currently she does not have further discomfort. The resident indicated she had a reaction related to a dialysis treatment which had stopped the blood flow to her feet and legs, causing necrosis to her bilateral lower extremities. The necrosis made it		•There are no corrective actions for Resident#185 since she was discharged to her home on 7/15/13. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken** •Residents who reside at the facility have thepotential to be affected by the alleged deficient practice. •The Unit Managers reviewed residents with anIndwelling Catheter for supporting diagnosis to its use. There were no negative findings. •Licensed nurses will be re-educated on IndwellingUrinary Catheter Assessments by the SDC/designee by 7/30/13. •Indwelling Urinary Catheter assessments arecompleted by the nurse/designee upon admission, re-admission, significantchange, quarterly, annually. •The DNS/designee will monitor for compliance. •Noncompliance with facility procedures mayresult in disciplinary action. **What measures will be putinto place or what systemic changes you will make to**	

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	difficult for her to move around. The resident indicated she constantly had pain in the bilateral lower extremities, however, repositioning does not add additional pain. During an interview with the DNS (Director of Nursing Services) and the East Wing Unit Manager on 7/11/13 at 3:07 p.m., a Bladder Continence Assessment Form was reviewed. The DNS and the Unit Manager indicated the diagnosis was not found on the assessment form. The DNS and the Unit Manager indicated the resident's last readmission on 6/11/13, indicated a diagnosis of discomfort with repositioning. The DNS and Unit Manager indicated the resident had intractable pain related to her wounds to her bilateral lower extremities, which made it difficult for the resident to be toileted and repositioned. The DNS and the Unit Manager #2 indicated the resident has had many admissions and had always returned from the hospital with the catheter. 3.1-41 (a)(2)		**ensure that the deficientpractice does not recur** •□□□□□□□Indwelling Urinary Catheter assessments arecompleted by the nurse/designee upon admission, re-admission, significantchange, quarterly, annually. •□□□□□□□Catheter use is reviewed by theInterdisciplinary Team to ensure acceptable diagnosis for catheter use indocumented in the medical record. •□□□□□□The DNS is responsible to ensure resident'splan of care and resident need sheet is an accurate reflection of residentsneeds. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •□□□□□□□The Unit Manager/designee will complete the "CatheterAssessment" CQI tool will be utilizedweekly x 4, then monthly thereafter for at least 6 months. •□□□□□□□If a threshold of 95% is not met an action plan will be created. •□□□□□□□Data will be submitted to the CQI Committeefor review and follow up. •□□□□□□□Noncompliance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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			facility procedures mayresult in disciplinary action.	

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F000318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review and interview, the facility failed to ensure appropriate treatment and services were provided in a timely manner for 2 of 7 residents reviewed for range of motion. (Resident #46 and #151) Findings included: 1. Resident # 46 was observed on 7/8/13 at 11:50 a.m. Resident #46's fingers were observed to be deformed and elbows were bent. There were no splints on the resident. During this time, the spouse was interviewed and indicated the resident had splints in her closet and had not worn them for "a while". Resident #46 was observed on 7/10/13 at 11:45 a.m. There were no splints on the resident's extremities. Resident #46 was observed on 7/15/13 at 9:55 a.m. There were no splints on the resident's extremities.	F000318	**F318** **INCREASE/PREVENTDECREASE IN RANGE OF MOTION** Based on thecomprehensive assessment of a resident, the facility must ensure that aresident with a limited range of motion receives appropriate treatment andservices to increase range of motion and/or to prevent further decrease inrange of motion. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□Resident #46 was reassessed and is receiving occupational therapy andrange of motion. •□□□□□□Resident #151 was reassessed and is currently receiving physical,occupational therapy and range of motion. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand**	08/15/2013

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NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383	

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	Resident #46 clinical record was reviewed on 7/10/13 at 11:30 a.m. Resident #46's diagnoses included, but were not limited to, neoplasm (tumor), brain intracranial abscess, cerebral edema, history of convulsions,dysphasia (difficulty swallowing), and respiratory failure/vent dependent. A care plan dated 1/27/11, indicated the resident had limited ROM and loss of voluntary movement. Interventions indicated to observe for signs and symptoms of pain, medicate and treat as needed, observe skin for any bruising, skin tears or abnormalities, and report to charge nurse, provide passive range of motion with ADL's (Activities of Daily Living), therapy to screen routinely, and weekly skin assessment and document any abnormal findings. Review of the February 2013 MAR (Medication Administration Record), indicated an order dated 5/10/12, for the resident to utilize elbow dynamic splint to the left elbow for 5 hours every day. The husband may apply and remove the splint. An Occupational Therapy Plan of		**what corrective action will be taken** •□□□□□□□All residents have the potential to beaffected by the alleged deficient practice. •□□□□□□□Therapy has verified that the resident's splint schedule is beingfollowed for residents that have a physicians order for splints. •□□□□□□□DNS/designee conducted an audit to ensure that residents withcontractures are receiving range of motion and/or appropriate splints. •□□□□□□□The nursing staff will be educated on donning/doffing of resident'ssplint usage by the RSM/SDC/designee by 7/30/13. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •□□□□□□□All residents are screened at least quarterly to determine the need forformal therapy and/or continued use of splints. •□□□□□□□Unit Managers andcharge nurses monitor resident care for the use of splints and receipt of rangeof motion by making rounds on their units daily per shift. Findings are documented on the NursingRounds Checklists. Concerns areaddressed with the	

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	Care dated 2/13/13, indicated the reason for the referral was due to an "increase in range of motion to the left elbow resulting from adjustment needed for the elbow brace." The level of function during the assessment indicated the resident did not tolerate the extension splint for "0 minutes" following the adjustment. The goal indicated the resident would be able to tolerate the extension splint for two hours with a short term goal date of 3/6/13. The long term goal was for the resident to achieve elbow flexion to 85 degrees and prevent contractures. Occupation Therapy was going to see the resident three times a week for four weeks. The resident was discharged to a hospital on 2/21/13 and returned on 3/8/13. Occupational Therapy was not resumed. A physician's order dated 7/10/13, indicated to add the diagnosis of contractures to upper and lower extremities. An interview with LPN #6 on 7/9/13 1:50 p.m., indicated Resident #46 had contractures to her bilateral fingers and elbows, did not wear a splint but received range of motion care every morning and every evening.		nursing aide, as needed. •□□□□□□□Rounds arecompleted each shift by the charge nurse, Monday – Friday, by department heads,to monitor resident care. Concerns areaddressed and documented on the Nursing Rounds Checklist and Customer CareRounds Sheets and discussed with the resident's charge nurse. •□□□□□□□The Director of Nursing Services is responsibleto monitor for facility compliance and will review the Nursing RoundsChecklists daily (Mon-Fri). •□□□□□□□The Customer Care Rounds Sheets will bereviewed during daily meetings by the ED/designee for compliance. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •□□□□□□□The Unit Managers/designee will complete the "Accommodation of Needs"CQI Tool weekly x 4 weeks and then monthly ongoing thereafter for at least 6months. •□□□□□□□If a threshold of 95% is not met an action plan will be created. •□□□□□□□Data will be submitted to the CQI Committeefor review and follow up.	

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	An interview with Restorative Aide #5 on 7/11/13 at 10:15 a.m., indicated nursing managed restorative care and the resident's spouse, who visited daily, would perform the resident's exercises. An interview with the Therapy Director on 7/11/13 at 10:30 a.m., indicated she was not made aware of the resident not wearing her splints and she would obtain an order to reassess the resident. An interview with the West Wing Unit Manager on 7/12/13 at 3:40 p.m., indicated the resident had been assessed for splints to the elbows but when she went to the hospital in (February, 2013) and returned, her husband did not want her to have her splints on and the resident's arms appeared to be less contracted at the time. An interview with the resident's spouse on 7/15/13 at 9:45 a.m., indicated he did not inform the staff to leave the splints off the resident. He indicated he had concern with the splint interfering with the resident's IV's (Intravenous) and had a PICC line in her arm. He indicated when the resident first got the splints, therapy educated him on how to put		•□□□□□□Noncompliance with facility procedures mayresult in disciplinary action	

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	the splints on. He indicated the CNAs were not allowed to do it because they were not educated on it. He indicated the splints were in the closet. The spouse indicated the resident's tone did decrease during hospitalization, but she still had some resistance in her elbows and her fingers. The spouse indicated he would do ROM (range of motion) with the resident but not on an every day consistent basis. The spouse also indicated he had requested another therapy evaluation due to the resident had shown some improvement since her last hospitalization in the spring. There had been no post assessments of range of motion when the resident returned from the hospital or when her PICC line was discontinued. 2. On 7/10/13 at 11:00 a.m., Resident #151 was observed with his hands contracted shut. There were no splints in place. On 7/10/13 at 3:00 p.m., Resident #151 was observed with his hands contracted shut. There were no splints in place. On 7/11/13 at 9:00 a.m., Resident #151 was observed with his hands contracted shut. There were no			

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	splints in place. On 7/12/13 at 3:00 p.m. Resident #151 was observed with his hands contracted shut. There were no splints in place. On on 7/15/13 at 10:00 a.m., Resident #151 was observed with his hands contracted shut. There were no splints in place. Resident #151's clinical record was reviewed on 7/10/13 at 11:00 a.m. Resident #151's diagnoses included, but were not limited to, anxiety disorder, pulmonary embolism (clot in the lungs), cardiomyopathy (enlarged heart), congestive heart failure, respiratory failure/ventilator dependent, quadriplegic, and CVA (stroke). A care plan dated 12/22/11, indicated the resident was dependent for ADL's (Activities of Daily Living) related to a diagnosis CVA (stroke) and quadriplegia. The interventions indicated on 12/8/12, to assess the resident through out the day for hygiene needs, assist with all ADL's, observe for and assistance with pain relief, and therapies as ordered/required.			

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NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383	

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	Review of the Occupational Therapy Discharge Summary dated 5/1/13, indicated the resident had progressed to 6 hours of tolerance of the left elbow splint and palmer splints to bilateral hand. A physician order dated 5/2/13, indicated for the resident to wear bilateral ankle boots at all times as tolerated to prevent foot drop. The Charge nurse was to check skin every shift. A care plan for potential for skin breakdown related to impaired mobility was updated on 5/3/13. The interventions indicated on 3/15/12, staff was to maintain bilateral upper extremities at all times on the forearm/hand by utilizing the positioning pillows provided by therapy. The bilateral hand splints were to be on at 10 p.m. and off at 6 a.m. On 5/3/13, the bilateral ankle boots were to be on at all times as tolerated. A quarterly MDS (Minimum Data Set) Assessment dated 5/6/13, indicated the resident was cognitively intact and the resident was totally dependent for ADL's. A care plan initiated on 5/6/13,			

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NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383	

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	indicated the resident required a splint/brace program 6-7 days a week to help prevent further contractures and pain. The interventions indicated to notify the nurse if the resident had signs of pain, apply bilateral lower extremity ankle boots, left elbow splint, and palmer splints to bilateral hands daily for 6 hours or as tolerated, stop exercise if resident had pain or discomfort and to notify the nurse. A care plan initiated on 5/6/13, indicated the resident required passive range of motion 6-7 days a week to help prevent contractures and pain related to the loss of voluntary movement due to a diagnosis of quadriplegia. The interventions indicated to observe and notify the nurse if resident had signs of pain. Nursing notes dated 6/16/13 to 6/19/13, indicated the resident had refused to wear his splints due to pain. Review of the June, 2013 TAR (Treatment Administration Record), indicated the resident had refused to wear his splints on 6/17/13 to 6/19/13 and 6/30/13.			

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	Review of the June Monthly Splint Program on 7/12/13 at 2:30 p.m., indicated the resident had worn his splints for 15 minutes daily. Review of the July, 2013 TAR (Treatment Administration Record), indicated the resident had refused to wear his splints on 7/4/13 to 7/10/13. Nursing notes dated 7/9/13 to 7/10/13, indicated the resident had refused to wear his splints. Review of the July Monthly Splint Program on 7/12/13 at 2:30 p.m., indicated the resident had worn his splints for 15 minutes daily. Review of the July, 2013 Physician Recapitulation Orders, an order dated 4/30/13, indicated the "resident may have palmer splint to left hand, palmer splint with finger separator to right hand and left elbow extension splint, for 6 hours per day. All splints on a.m. off p.m. and wear as tolerated. The Charge nurse was to check for skin breakdown, redness and edema every 2 hours when the splints were in use." An interview with the Therapy Director on 7/11/13 at 10:30 p.m., indicated the therapy department was just			

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	made aware of the resident's refusal to wear the splints and therapy did assess the resident on 7/10/13. Therapy was waiting for orders from the physician. The Therapy Director indicated multiple things had been attempted with the resident to ease his discomfort but his tone was very bad. The Therapy Director indicated the resident had not been able to tolerate getting out of bed due to pain and broncho spasms. The Therapy Director indicated different cushions and chairs had been attempted without success. 3.1-42(a)(2)			

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	155166		07/16/2013

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F000431 SS=D	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 records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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. Based on observation, interview, and record review, the facility failed to ensure a Medication Room did not have expired medications related to	F000431	**F431 DRUG RECORDS,LABEL/STORE DRUGS & BIOLOGICALS**	08/15/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/16/2013
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	expired intravenous fluids (IV) for 2 of 4 resident's IV medications observed in 1 of 2 medication rooms. (West Unit) (Residents #103 and #107) Findings include: During an observation of the West Unit Medication room on 07/09/13 at 2:10 p.m. with the Evening Supervisor present, there were two bags of 0.9% normal saline, with expiration dates of 06/23/13 and 07/05/13 for Resident #103 and two bags of dextrose in water for Resident #107, with expiration dates of 07/06/13. Each of the bags had an antibiotic to mix with the fluid, which were not expired. The Evening Supervisor indicated at the time of the observation, the nurses' check the Medication Room at random for expiration dates of the medication. During an interview on 07/10/13 at 9:45 a.m., the West Unit Manager indicated the IV medication had been completed for Residents' #103 and #107 and had not been removed from the Medication Room when the medication had been completed. An undated facility policy, titled, "Expiration Dates", received from the		It is the practice of this provider to employ or obtainthe services of a licensed pharmacist who establishes a system of records ofreceipt and disposition of all controlled drugs in sufficient detail to enablean accurate reconciliation; and determines that drug records are in order andthat an account of all controlled drugs is maintained and periodicallyreconciled. Thisprovider ensures that drugs and biologicals used in the facility must belabeled in accordance with currently accepted professional principles, andinclude the appropriate accessory and cautionary instructions, and theexpiration date when applicable. **What corrective action(s)will be accomplished for those residents found to have been affected by thedeficient practice** •□□□□□□□Expired medications were disposed of immediately. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken** •□□□□□□□All residents have the potential to beaffected by the	

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	Director of Nursing as current on 07/09/13 at 3:30 p.m., indicated, "...Medication must be checked regularly for expiration dates and deterioration. Expired medications will be removed from use and destroyed as per the facility's policy and procedure..." 3.1-25 (k)(6)		alleged deficient practice. •□□□□□□Nurses will be educated to ensure medicationsare discarded when expired and/or returned to the pharmacy upon non-use by theSDC/designee by 7/30/13. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •□□□□□□Charge nurses will check expiration dated prior to medicationadministration. •□□□□□□The Unit Managers/designee will check medication storage room fordiscontinued/expired medications daily. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •□□□□□□□Observations willbe documented on the “Medication Storage Review” CQI tools weeklyx 4, then monthly thereafter by the DNS/designee for at least 6 months. •□□□□□□□If a threshold of 95% is not met an action plan will be created. •□□□□□□□Data will be submitted to the CQI Committeefor review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/16/2013

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			follow up. •□□□□□□Noncompliance with facility procedures mayresult in disciplinary action	

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F000520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS 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. 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. 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. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility failed to ensure social services were managing and monitoring behaviors for 2 of 3 residents with behaviors in a sample of 10. The facility also failed to ensure social services followed up on a Prior Authorization for a resident in need of new dentures for 1 of 40 residents reviewed for dental services. The facility also failed to properly assess and monitor	F000520	**F520** **QAACOMMITTEE-MEMBERS/MEET QUARTERLY/PLANS** Afacility must maintain a quality assessment and assurance committee consistingof the director of nursing services; a physician designated by the facility;and at least 3 other members of the facility's staff. Thequality assessment and assurance committee meets at least quarterly to identifyissues	08/15/2013

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	resident's with a perma-catheter for 1 of 1 resident's reviewed for dialysis. (Resident #90, #91, #185 and #195) Findings include: During an interview with the Executive Director (ED), the Director of Nursing Services (DNS) on 7/16/13 at 3:00 p.m., the DNS indicated she had identified and addressed the behavioral monitoring/documentation of behaviors to the staff but had not brought it to the attention of the QAA. The DNS indicated she had not addressed the assessment and monitoring of perma catheters and was not aware of Social Services not following up on dental services. 3.1-52(b)(2)		with respect to which quality assessment and assurance activities arenecessary; and develops and implements appropriate plans of action to correctidentified quality deficiencies. AState or the Secretary may not require disclosure of the records of suchcommittee except insofar as such disclosure is related to the compliance ofsuch committee with the requirements of this section. Goodfaith attempts by the committee to identify and correct quality deficiencieswill not be used as a basis for sanctions. **What corrective action(s)will be accomplished for those residents found to have been affected by the deficientpractice** •□□□□□□□Resident #90's Social Service Behavior Monthly Summary forms and careplans have been reviewed and updated as indicated. •□□□□□□□Resident #195 was placed on Behavior monitoring and the care plan wasupdated as indicated. •□□□□□□□Prior authorization was resubmitted for Resident #91's denturereplacement by the dentist.	

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			•There are no corrective actions for Resident#185 since she was discharged to her home on 7/15/13. **How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken** •All residents have the potential to beaffected by the alleged deficient practice. •Continuous Quality Improvement Committee willaddress behaviors, dental prior authorizations and perma catheters. **What measures will be putinto place or what systemic changes you will make to ensure that the deficientpractice does not recur** •The Continuous Quality Improvement schedule has been updated and willbe educated to all members by the ED/designee by 7/30/13. •The Continuous Quality Improvement audits will be completed per theschedule and discussed at the monthly meeting. •Action plans will be written and staff educated when thresholds are notmet.	

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			•□□□□□□The Executive Director will monitor for compliance monthly ongoing. **How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place** •□□□□□□The Executive Director will monitor the CQI schedule monthly ongoing toensure compliance. •□□□□□□If a threshold of 95% is not met an action plan will be created. •□□□□□□Data will be submitted to the CQI Committeefor review and follow up. •□□□□□□Noncompliance with facility procedures mayresult in disciplinary action	