

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155754	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2015
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NAME OF PROVIDER OR SUPPLIER  HUBBARD HILL ESTATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 28070 CR 24 ELKHART, IN 46517
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: March 17, 18, 19, 20, 23, 24 and 25, 2015.</p> <p>Facility number: 001131 Provider number: 155754 AIM number: 200823940</p> <p>Survey Team: Lora Swanson, RN-TC Sharon Ewing, RN Deb Kammeyer, RN Julie Wagoner, RN</p> <p>Census bed type: SNF: 52 SNF/NF: 8 Residential: 104 Total: 164</p> <p>Census payor type: Medicare: 24 Medicaid: 8 Other: 28 Total: 60</p> <p>Residential Sample: 7</p>	F 000		
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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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F 272 SS=D Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on April 1, 2015, by Brenda Meredith, RN.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;</p>			

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	<p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>Based on observation, record review and interview, the facility failed to ensure a decline in bladder continency was thoroughly assessed to restore as much bladder function as possible for 1 of 1 residents reviewed for urinary continence. (Resident #29)</p> <p>Finding includes:</p> <p>Resident #29 was observed, on 03/18/15 at 9:24 A.M., seated in her room in her wheelchair. The resident was noted to smell strongly of urine.</p> <p>The clinical record for Resident #29 was reviewed on 03/20/2015 at 9:35 A.M. Resident #29 was readmitted to the facility on 01/05/15 with diagnoses, including but not limited to abnormal gait, atrial fibrillation, difficulty in walking, status post internal fixation of a hip fracture, weakness, hypertension, osteoporosis and CVA (Cerebral Vascular Accident).</p> <p>A Quarterly MDS (Minimum Data Set) assessment, completed on 11/13/14,</p>	F 272	<p>Resident #29 has completed a three day patterning for toileting, Bowel and Bladder Assessment Form has been completed and care plan has been updated to include toileting upon rising, before and after meals, prior to bed and as needed. All Bowel and Bladder Assessment Forms will be reviewed and compared to the previous Bowel and Bladder Assessment Form. If decline noted, a 3 day voiding pattern will be initiated, and care plans will be updated to include appropriate interventions. In addition, all residents readmitted since 1/1/15, will have a 3 day voiding pattern completed and care plan updated to reflect changes.</p> <ol style="list-style-type: none"> <li>1. Nursing staff to be inserviced regarding Hubbard Hill Urinary Incontinence Management Policy effective 4/15/15.</li> <li>2. Upon admission, or readmission, the admission nurse will initiate the 3 day pattern form for toileting.</li> <li>3. The Bowel and Bladder Assessment Form will be completed by the Unit Manager/designee after the 3 day patterning is complete. Following the completion of the Bowel and Bladder Assessment, an</li> </ol>	04/17/2015

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	<p>indicated the resident was continent of her bladder, required supervision oversight only for toileting and ambulation needs.</p> <p>A Significant Change MDS assessment, completed on 01/12/15, indicated the resident required extensive assistance of two staff for transfer needs, was not ambulating, required extensive staff assistance for wheelchair locomotion, required extensive staff assistance of two staff for toileting needs and personal hygiene needs, and was frequently incontinent of her bladder.</p> <p>The bowel and bladder assessment, completed on 01/06/15, indicated the resident had a recent onset of incontinence, had leakage and/or dribbling after urinating, when coughing, sneezing, laughing, exercising, and if delayed going to the toilet. The section of the assessment to indicated how often the resident usually urinated during the day, how many hours between times she needed to urinate was left blank. The assessment indicated the resident was "Incontinent - has inadequate control of bladder, multiple daily episodes."</p> <p>The 3-day voiding pattern record, completed on 01/05/15 - 01/07/15 indicated the tracking was initiated on</p>		<p>appropriate care plan will be initiated by the Unit Manager/designee.</p> <p>4.A Bowel and Bladder Assessment Form will be completed quarterly, with any significant change, and with any readmission by the Unit Manager or designee. If declined, the 3 day pattern form will be initiated. The care plan will be updated to reflect changes.</p> <p>5. Nursing Unit Managers to audit all residents on three day patterning to assure completion daily on scheduled days of work.</p> <p>Results of the Unit Manager audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/VP of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p>	

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	<p>01/05/15 at 5:00 P.M. The resident was toileted with a bed pan. The next documentation indicated at 8:00 P.M. the resident was incontinent. There was no indication she had been toileted between 5:00 P.M. - 8:00 P.M. At 9:00 P.M. the resident was toileted with a bed pan and voided. She was also marked as having been slightly incontinent. There was no further documentation until 01/06/15 at 1:00 A.M. when the resident was toileted, was dry, and was given a drink. It was not clear if she voided at 1:00 A.M. From 1:00 A.M. - 7:00 A.M., there was no documentation the resident was toileted. At 7:00 A.M. on 01/06/15 she was very wet and a bed pan was documented in the comments section but it was not clear if the resident voided. She was documented as very wet and voided a large amount at 10:00 A.M. but the toilet was marked out. The same documentation was completed for 12:00 P.M. and 2:00 P.M. At 4:00 P.M. the resident was documented as very wet but there was no documentation of any opportunities of toileting until 7:00 P.M. At 9:00 P.M., she was documented as dry but no toileting documented. There was no further documentation from 10:00 P.M. on 01/06/15 through the whole day on 01/07/15.</p> <p>The care plan related to urinary</p>			

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	<p>incontinence, originally initiated on 05/14/14, indicated the resident had a history of functional urinary incontinence related to cognitive deficits and impaired mobility. The goal was for the resident to have less than two episodes of incontinence per day. The interventions were: "observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. See Restorative care plan, check resident every two hours and assist with toileting as needed, provide urinal/bedpan/bedside commode, provide pericare after each incontinent episode, keep call light within reach, and remind resident to call for assistance, monitor for signs and symptoms of urinary tract infection, provide loose fitting, easy to remove clothing, refer to physical therapy and occupational therapy as indicated, see care plans on physical mobility, transfers, cognitive deficit, communication."</p> <p>Under the date section the care plan had been marked as "readmit 01/05/15" but the interventions had not been changed and/or revised from her previous status.</p> <p>During an Interview, on 03/20/2015 at 10:37 A.M., CNA #1 indicated before Resident #29 had a stroke, she was more continent and could let you know 95 % of the time when she needed to urinate. CNA #1 indicated now she was</p>			

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	<p>dependent, still told staff at times when she needed to urinate but was often wet, especially if she had been given pain meds as they tended to make her sleep more. CNA #1 indicated the resident was often incontinent of her bladder and did not always ask to go to the bathroom.</p> <p>The policy and procedure for Urinary Incontinence/Management of Urinary Incontinent, effective 05/01/2014, was provided by the Director of Nursing on 3/24/15 at 10:50 A.M. and indicated it was the policy and procedure currently used by the facility. The policy and procedure indicated the following: "If a resident is identified to have incontinent episodes of the bladder, the following will be completed. 1. Complete the 3-day tracking form to help determine pattern of incontinence for suspected or known incontinence upon admission, onset of new incontinence, or quarterly, if change in incontinence is noted on MDS assessment. 2. Completed Bowel and Bladder Assessment on admission, quarterly, or when resident develops an incontinence problem. 3. Initiate/update plan of care to address alterations in bladder."</p> <p>3.1-31(b)</p>			

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F 279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review, and interview the facility failed to ensure a care plan regarding addressing the resident's signs and/or symptoms of anxiety was developed for 1 of 5</p>	F 279	<p>Resident #34 has had care plan updated to address the resident's signs and symptoms of anxiety</p> <p>Resident #10 has a "Potential for Falls" care plan in place.</p>	04/17/2015

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	<p>residents reviewed for unnecessary medications. (Resident #34) In addition, the facility failed to ensure a potential for fall risk care plan was developed prior to a fall for 1 of 2 residents reviewed for falls. (Resident #10)</p> <p>Findings include:</p> <p>1. Resident #34 was observed, during the day time hours, on 03/17/15 and 03/18/15, seated in his room in a recliner or in his wheelchair. The resident was often noted to keep his eyes closed and sleep, did not speak and did not exhibit any symptoms of anxiety.</p> <p>The clinical record for Resident #34 was reviewed on 03/23/2015 at 10:25:47 AM. Resident #34 was admitted to the facility, on 06/27/08, with diagnoses, including but not limited to, dementia with behavioral disturbances, Alzheimer's disease, mood disorders, adjustment disorder with depression, psychosis, constipation, peripheral vascular disease and depressive disorder.</p> <p>The current physician's orders for medication included orders for the resident to receive the anti-anxiety medication Lorazepam 0.5 mg (milligrams) at bedtime and 0.25 mg in the morning for "anxiety." The resident</p>		<p>All residents with a diagnosis of anxiety, and receiving anti-anxiety medication, have had their care plans reviewed and updated to include signs, symptoms, behaviors and appropriate interventions. All resident's Fall Risk Assessments have been reviewed and those at risk for fall have an appropriate care plan in place.</p> <p>1. Nursing and Social Service staff to be serviced regarding Behavior Assessment and Monitoring Policy effective 4/15/15.</p> <p>2. Hubbard Hill Care Plan Policy will be reviewed with Nursing and Social Service staff, effective 4/15/15.</p> <p>3. All new admissions are to be reviewed by the Social Service Manager or designee to capture residents utilizing anti-anxiety medications. The Social Service Manager or designee will ensure that care plans reflect specific anxiety signs, symptoms and behaviors as well as appropriate interventions.</p> <p>4. The Unit Manager, or designee will forward copies of physician orders, on scheduled days of work, to the Social Service Manager/designee to capture newly ordered anti-anxiety medications. The Social Service Manager/designee will ensure that care plans reflect specific anxiety signs, symptoms, and behaviors as well as</p>				

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	<p>also had a physician's order to receive the antianxiety medication Atarax 10 mg at bedtime. The resident also received the antipsychotic/antiseizure medication, Divalproex 125 mg once a day to treat a diagnosis of Dementia with behavioral disturbances.</p> <p>The current behavioral monitoring for Resident #34, located in the Medication Administration Record book, was for the behaviors of resistive to care and combativeness. The tracking form had both the Depakote (Divalproex) and Lorazepam medications listed on the form.</p> <p>The current health care plans for Resident #34 included a plan to address the resident's history of being physically abusive during care, a plan to address the potential side effects of the antianxiety medication use, and a plan to address the Depakote medication use to due Dementia with behavioral disturbances. There was no plan to address the resident's signs and/or symptoms of anxiety and no interventions to address the resident's anxiety.</p> <p>The antianxiety/hypnotic medication use care plan, initiated on 09/26/12 and reviewed on 03/12/15 indicated the resident had a diagnosis of anxiety and</p>		<p>appropriate interventions.</p> <p>5. The MDS nurse will audit 5 non-assigned residents to assure care plans are updated to include signs, symptoms and interventions for residents having a diagnosis of anxiety and using anti-anxiety medications. The MDS nurse will audit weekly x 4, bi-monthly x 2, then quarterly.</p> <p>6. A "Fall Risk Assessment" will be completed upon admission. A care plan will be initiated if the resident is deemed at risk. The MDS nurse will complete the fall risk assessments quarterly, and with condition change. Care plans will be developed to reflect appropriate interventions, based on assessment.</p> <p>7. The MDS nurse will audit 5 non-assigned residents to assure fall risk care plans are updated. The MDS audits will be weekly x 4, bi-monthly x 2, then quarterly.</p> <p>Results of the MDS nurse audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/VP of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p>		

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	<p>received Atarax and Lorazepam. The interventions were to provide medications as ordered, monitor for possible side effects from medication every shift using side effects monitoring flow sheet. Provide interventions and document prior to giving PRN medications, monitor lab work ordered, notify physician if interventions ineffective or side effects are noted. The dates and reduced medication doses of Depakote and Ativan were noted on the care plan but there were no specific behaviors related to anxiety or interventions to address the anxiety noted on the care plan. There was a monthly behavior monitoring flowsheet for the targeted behaviors of resistive care and combative and both Ativan and Depakote were noted on the psychoactive medication. There were 12 nonspecific interventions on the form to document. The resident had not exhibited either behavior in January, February or March 2015.</p> <p>During an interview on 03/23/2015 at 11:32 A.M., the unit manager, RN #3, after she looked through the care plans, indicated she would contact another staff member " to check into that" related to no care plan to address anxiety. During an interview, on 03/23/2015 at 1:56 P.M., RN #3 indicated they were still unable to</p>			

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	<p>locate a care plan related to the resident's anxiety.</p> <p>During an interview, on 03/23/2015 at 2:51 P.M., RN #3 indicated the resident exhibited his anxiety by becoming restless, rocking, and scratching/rubbing his skin all over even though there was no rash or observed skin issue. The unit manager marked out "pacing" which was listed on the care plan. There was no behavior monitoring for these behaviors on the behavior log form.</p> <p>On 03/24/15 at 10:30 A.M., the Director of Nursing presented a copy of a care plan related to Resident #34's history of becoming combative with care. The plan had various dose reductions for both the Depakote and Ativan medications noted on the plan. However, the plan did not address the resident's anxiety issues which he displayed by restlessness, rocking, and scratching. There was no other information given regarding the care plan.</p> <p>2. On 3/20/15 at 1:50 P.M., a review of the clinical record for resident #10 was conducted. The record indicated the resident was admitted on 4/17/12. The resident's diagnoses included, but were not limited to: history of below knee</p>			

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	<p>amputation, anemia, osteoporosis, angina, pacemaker, and hypertension.</p> <p>Nursing Notes, dated 3/12/15 at 7:15 P.M., indicated Resident #10 was being transferred from wheelchair to toilet and the resident's prosthetic leg fell off. A staff member assisted the resident to the floor slowly and notified the nurse. The resident did not receive any injuries. The resident was transferred from the floor to the toilet with the assistance of 3 staff members.</p> <p>A Fall Risk Assessment, dated 12/18/14, indicated the resident was a high risk for a fall, with a score of 12. A Fall Risk Assessment was completed again on 3/12/15. The score was a 10 which indicated he was a high risk for falls.</p> <p>An Event Report, dated 3-12-15 at 7:00 P.M., indicated the resident had a witnessed fall, by being assisted to the floor by a Certified Nursing Assistant. During a transfer to the toilet, the resident's prosthesis, to his right leg shifted and fell to the ground. The resident was unable to bear weight on his right side. The resident was assisted to a sitting position on the floor. The resident was currently in the process for a new prosthesis from a local orthopaedic company. The physician, family, DON</p>			

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	<p>(Director of Nursing) and Administrator were notified the day the incident occurred.</p> <p>A Careplan, dated 3/13/15, indicated the resident was at risk for a fall related to unsteady gait and right below knee amputation with prosthesis. The interventions included but were not limited to: maintain record of falls and evaluate for patterns, make sure all staff were aware the resident was at high risk for falls, assure prosthetic is on properly and currently in process for new prosthesis</p> <p>During an interview, on 3-23-15 at 9:05 A.M., the Director of Nursing indicated she could not locate a fall risk care plan for Resident #10 prior to his fall on 3-12-15. The DON further indicated the the fall on 3/12/15 was the resident's first fall since his admission.</p> <p>On 3/23/15 at 2:20 P.M., the DON provided a policy titled, "Care Plan," dated 11/1/11, and indicated the policy was the one currently used by the facility. The policy indicated "...2. Each resident's Comprehensive Care Plan has been designed to...b. Incorporate risk factors associated with identified problems...f. Aid in preventing or reducing declines in the resident's functional status and/or</p>			

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F 282 SS=D Bldg. 00	<p>functional levels...."</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to follow the toileting care plan for 1 of 9 residents reviewed for care plans. (Resident #29)</p> <p>Finding includes:</p> <p>Resident #29 was observed, on 03/18/15 at 9:24 A.M., seated in her room in her wheelchair. The resident was noted to smell strongly of urine.</p> <p>The clinical record for Resident #29 was reviewed on 03/20/2015 at 9:35 A.M. Resident #29 was readmitted to the facility on 01/05/15 with diagnoses, including but not limited to abnormal gait, atrial fibrillation, difficulty in walking, status post internal fixation of a hip fracture, weakness,</p>	F 282	<p>Resident #29 has completed a three day patterning for toileting and the care plan and the CNA assignment sheet has been updated to include toileting upon rising, before and after meals, prior to bed and as needed.</p> <p>All residents with incontinence have had their care plans reviewed for accuracy, and CNA assignment sheets updated to reflect the care plan.</p> <p>1. Nursing staff to be inserviced related to Hubbard Hill Care Plan Policy, effective 4/15/15 2. All residents readmitted will have the 3 day pattern form completed. 3. The Bowel and Bladder Assessment Form will be completed by the Unit Manager/designee after the 3 day patterning is complete. Following the completion of the Bowel and</p>	04/17/2015	

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	<p>hypertension,osteoporosis and CVA (Cerebral Vascular Accident).</p> <p>The care plan related to urinary incontinence for Resident #29, originally initiated on 05/14/14, indicated the resident had a history of functional urinary incontinence related to cognitive deficits and impaired mobility. The goal was for the resident to have less than two episodes of incontinence per day. The interventions were: "observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. See Restorative care plan, check resident every two hours and assist with toileting as needed, provide urinal/bedpan/bedside commode, provide pericare after each incontinent episode, keep call light within reach, and remind resident to call for assistance, monitor for signs and symptoms of urinary tract infection, provide loose fitting, easy to remove clothing, refer to physical therapy and occupational therapy as indicated, see care plans on physical mobility, transfers, cognitive deficit, communication." Under the date section the care plan had been marked as "readmit 01/05/15" but the interventions had not been changed and/or revised from her previous status.</p> <p>During an Interview, on 03/20/2015 at</p>		<p>Bladder Assessment, an appropriate care plan will be initiated bythe Unit Manager/designee.</p> <p>4.The CNA assignment sheet will be updated toreflect the Urinary Incontinence care plan interventions.</p> <p>5.The MDS nurse will audit 5 non-assignedresidents to assure Urinary Incontinence care plan interventions are reflectedon the CNA assignment sheets. The MDS audits will be weekly x 4, bi-monthlyx 2, then quarterly.</p> <p>Results of the MDS nurse audits will be reviewed at theClinical Management Meeting with the Director of Nursing/VP of QualityManagement, and quarterly at the QA meeting x 2. At that time will review for continued needfor auditing.</p>	

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	<p>10:37 A.M., CNA #1 indicated before Resident #29 had a stroke (December 2014), she was more continent and could let you know 95 % of the time when she needed to urinate. CNA #1 indicated now she was dependent, still told staff at times when she needed to urinate but was often already wet, especially if she had been given pain meds as they tended to make her sleep more. CNA #1 indicated the resident was often incontinent of her bladder and did not always ask to go to the bathroom. CNA #1 had an assignment sheet that did not have any specific instructions for toileting Resident #29. CNA #1 indicated she checked on Resident #29 in the early A.M., toileted her when she got her up for breakfast, toileted her after breakfast and transferred her to her recliner, then checked on her frequently, about every 30 to 45 minutes or so. She indicated now the resident does not always remember to use her call light if she needs help where before her stroke she would always use call light and did not always ask to go to the bathroom.</p> <p>The CNA assignment sheet for Resident #29, undated, observed on 03/20/15 at 10:37 A.M. with CNA #1, indicated there were no specific instructions regarding toileting. However, by the time a copy was requested of the CNA assignment</p>			

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	<p>sheet, on 03/20/15 the following instruction had been typed on the section for toileting needs "toilet per resident's request and as needed." The intervention did not reflect the resident's assessment, care plan, or current status.</p> <p>Resident #29 was observed, on 03/23/2015 at 9:38 A.M., in her room in her wheelchair. CNA #1 had just brought her back to her room from the dining room. Resident #29 was complaining of pain and CNA #1 informed the nurse. CNA #1 informed Resident #29 that therapy would be here pretty quick and also the nurse, RN #2 was going to see about giving her something for her runny nose. Resident #29 was not observed to have been toileted, nor was she asked if she needed to go to the toilet.</p> <p>The nurse, RN #2 was observed, on 03/23/2015 at 9:46 A.M., in the room with Resident #29. RN #2 indicated she had given Resident #29 some Tylenol medication.</p> <p>On 03/23/2015 at 10:04 A.M., a staff member went into Resident #29's room and replaced a styrofoam cup with fresh ice water. Resident #29 remained in her room in her wheelchair. She was not toileted nor was she asked if she needed to use the restroom.</p>			

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	<p>On 03/23/2015 at 10:08 A.M., Resident #29 was pushed by a therapy staff member to the therapy room.</p> <p>On 03/23/15 at 10:25 A.M., Resident #29 was still in the therapy room seated in her wheelchair.</p> <p>On 03/23/15 at 11:00 A.M., Resident #29 was still in the therapy room seated in her wheelchair now receiving electrical stimulation therapy to her arm.</p> <p>On 03/23/2015 at 11:17 A.M., Resident #29 was pushed from the therapy gym into her room, her bedside table was set up next to her wheelchair. She was not toileted or assisted with incontinence care. She remained in her room in her wheelchair from 11:17 to 11:33 A.M.</p> <p>On 03/23/2015 at 11:50 A.M., CNA #1 entered Resident #29's room and told the resident it was time for lunch. She repeated she was going to take the resident to have lunch and then she could come back and take a nap. The whole conversation was overheard and she did not ask Resident #29 if she had to go to the restroom nor did she toilet her. She was pushed in her wheelchair to the dining room.</p>			

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F 315 SS=D Bldg. 00	<p>3.1-35(g)(2)</p> <p>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.</p> <p>Based on observation, record review and interview, the facility failed to ensure a decline in bladder continency was thoroughly assessed and interventions implemented to restore as much bladder function as possible for 1 of 1 residents</p>	F 315	Resident #29 has completed a three day patterning for toileting, Bowel and Bladder Assessment Form has been completed and care plan has been updated to include toileting upon rising, before and after meals, prior to bed and as needed. All Bowel and Bladder Assessment Forms will be reviewed and compare	04/17/2015

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	<p>reviewed for urinary continence. (Resident #29)</p> <p>Finding includes:</p> <p>Resident #29 was observed, on 03/18/15 at 9:24 A.M., seated in her room in her wheelchair. The resident was noted to smell strongly of urine.</p> <p>The clinical record for Resident #29 was reviewed on 03/20/2015 at 9:35 A.M. Resident #29 was readmitted to the facility on 01/05/15 with diagnoses, including but not limited to abnormal gait, atrial fibrillation, difficulty in walking, status post internal fixation of a hip fracture, weakness, hypertension, and osteoporosis. The resident also was status post CVA (Cerebral Vascular Accident) on 12/20/14.</p> <p>A Quarterly MDS (Minimum Data Set) assessment, completed on 11/13/14, indicated the resident was continent of her bladder, required supervision oversight only for toileting and ambulation needs.</p> <p>A Significant Change MDS assessment, completed on 01/12/15, indicated the resident required the extensive assistance of two staff for transfer needs, was not ambulating, required extensive staff</p>				<p>to the previous Bowel and Bladder Assessment Form. If decline noted, a 3 day voiding pattern will be initiated, and care plans will be updated to include appropriate interventions. In addition, all residents readmitted since 1/1/15, will have a 3 day voiding pattern completed and care plan updated to reflect current status and interventions.</p> <p>1. Nursing staff to be inserviced regarding Hubbard Hill Urinary Incontinence Management Policy effective 4/15/15.</p> <p>2. Upon admission, or readmission, the admission nurse will initiate the 3 day pattern form for toileting.</p> <p>3. The Bowel and Bladder Assessment Form will be completed by the Unit Manager/designee after the 3 day patterning is complete. Following the completion of the Bowel and Bladder Assessment, an appropriate care plan will be initiated by the Unit Manager/designee.</p> <p>4. CNA assignment sheets will be updated to reflect the care plan interventions.</p> <p>5. A Bowel and Bladder Assessment Form will be completed quarterly, with any significant change, and with any readmission by the Unit Manager or designee. If decline noted, the 3 day pattern form will be initiated. The care plan and CNA assignment sheets will be updated to reflect changes.</p>		

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	<p>assistance for wheelchair locomotion, required extensive staff assistance of two staff for toileting needs and personal hygiene needs, and was frequently incontinent of her bladder.</p> <p>The bowel and bladder assessment, completed on 01/06/15, indicated the resident had a recent onset of incontinence, had leakage and/or dribbling after urinating, when coughing, sneezing, laughing, exercising, and if delayed going to the toilet. The section of the assessment to indicated how often the resident usually urinated during the day, how many hours between times she needed to urinate was left blank. The assessment indicated the resident was "Incontinent - has inadequate control of bladder, multiple daily episodes."</p> <p>The 3-day voiding pattern record, completed on 01/05/15 to 01/07/15 indicated the tracking was initiated on 01/05/15 at 5:00 P.M. The resident was toileted with a bed pan. The next documentation indicated at 8:00 P.M. the resident was incontinent. There was no indication she had been toileted between 5:00 P.M. to 8:00 P.M. At 9:00 P.M., the resident was toileted with a bed pan and voided. She was also marked as having been slightly incontinent. There was no further documentation until 01/06/15 at</p>		<p>6.The MDS nurse will audit 5 non-assigned residents to assure care plan interventions are reflected on the CNA assignmentsheets. The MDS audits will be weekly x 4, bi-monthly x 2, then quarterly.</p> <p>Results of the MDS Nurse audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/VP of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p>		

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	<p>1:00 A.M. when the resident was toileted, was dry and was given a drink. It was not clear if she voided at 1:00 A.M. From 1:00 A.M. to 7:00 A.M., there was no documentation the resident was toileted. At 7:00 A.M. on 01/06/15, she was very wet and a bed pan was documented in the comments section but it was not clear if the resident voided. She was documented as very wet and voided a large amount at 10:00 A.M. but the toilet was marked out. The same documentation was completed for 12:00 P.M. and 2:00 P.M. At 4:00 P.M., the resident was documented as very wet but there was no documentation of any opportunities of toileting until 7:00 P.M. At 9:00 P.M., she was documented as dry but no toileting documented. There was no further documentation from 10:00 P.M. on 01/06/15 through the whole day on 01/07/15.</p> <p>The care plan related to urinary incontinence, originally initiated on 05/14/14, indicated the resident had a history of functional urinary incontinence related to cognitive deficits and impaired mobility. The goal was for the resident to have less than two episodes of incontinence per day. The interventions were: "observe pattern of incontinence, and initiate toileting schedule or prompted voiding if indicated. See</p>			

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	<p>Restorative care plan, check resident every two hours and assist with toileting as needed, provide urinal/bedpan/bedside commode, provide pericare after each incontinent episode, keep call light within reach, and remind resident to call for assistance, monitor for signs and symptoms of urinary tract infection, provide loose fitting, easy to remove clothing, refer to physical therapy and occupational therapy as indicated, see care plans on physical mobility, transfers, cognitive deficit, communication."</p> <p>Under the date section the care plan had been marked as "readmit 01/05/15" but the interventions had not been changed and/or revised from her previous status.</p> <p>During an interview, on 03/20/2015 at 10:37 A.M., CNA #1 indicated before Resident #29 had a stroke, she was more continent and could let you know 95 % of the time when she needed to urinate. CNA #1 indicated now she was dependent, still told staff at times when she needed to urinate but was often wet, especially if she had been given pain meds as they tended to make her sleep more. CNA #1 indicated the resident was often incontinent of her bladder and did not always ask to go to the bathroom. CNA #1 had an assignment sheet that did not have any specific instructions for toileting Resident #29. CNA #1 indicated</p>			

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	<p>she checks on Resident #29 in the early A.M., toileted her when she got her up for breakfast, toileted her after breakfast and transferred her to her recliner, then checked on her frequently, about every 30 to 45 minutes or so. She indicated the resident does not now always remember to use her call light if she needs help where before her stroke she would always use call light</p> <p>The CNA assignment sheet for Resident #29, undated, observed on 03/20/15 at 10:37 A.M. with CNA #1, indicated there were no specific instructions regarding toileting. However, by the time a copy was requested of the CNA assignment sheet, on 03/20/15 the following instruction had been typed on the section for toileting needs "toilet per resident's request and as needed." The intervention did not reflect the resident's assessment, care plan, or current status.</p> <p>Resident #29 was observed, on 03/23/2015 at 9:38 A.M., in her room in her wheelchair. CNA #1 had just brought her back to her room from the dining room. Resident #29 was complaining of pain and CNA #1 informed the nurse. CNA #1 informed Resident #29 that therapy would be here pretty quick and also the nurse, RN #2 was going to see about giving her something for her runny</p>			

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	<p>nose. Resident #29 was not observed to have been toileted, nor was she asked if she needed to go to the toilet.</p> <p>The nurse, RN #2, was observed on 03/23/2015 at 9:46 A.M. in the room with Resident #29. RN #2 indicated she had given Resident #29 some Tylenol medication.</p> <p>On 03/23/2015 at 10:04 A.M., a staff member went into Resident #29's room and replaced a styrofoam cup with fresh ice water. Resident #29 remained in her room in her wheelchair. She was not toileted nor was she asked if she needed to use the restroom.</p> <p>On 03/23/2015 at 10:08 A.M., Resident #29 was pushed by a therapy staff member to the therapy room.</p> <p>On 03/23/15 at 10:25 A.M., Resident #29 was still in the therapy room seated in her wheelchair.</p> <p>On 03/23/15 at 11:00 A.M., Resident #29 was still in the therapy room seated in her wheelchair now receiving electrical stimulation therapy to her arm.</p> <p>On 03/23/2015 at 11:17 A.M., Resident #29 was pushed from the therapy gym into her room, her bedside table was set</p>			

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	<p>up next to her wheelchair. She was not toileted or assisted with incontinence care. She remained in her room in her wheelchair from 11:17 to 11:33 A.M.</p> <p>On 03/23/2015 at 11:50 A.M., CNA #1 entered Resident #29's room and told the resident it was time for lunch. She repeated she was going to take the resident to have lunch and then she could come back and take a nap. The whole conversation was overheard and she did not ask Resident #29 if she had to go to the restroom nor did she toilet her. She was pushed in her wheelchair to the dining room.</p> <p>The policy and procedure for Urinary Incontinence/Management of Urinary Incontinent, effective 05/01/2014, was provided by the Director of Nursing, on 3/24/15 at 10:50 A.M., and indicated it was the policy and procedure currently used by the facility. The policy and procedure indicated the following: "If a resident is identified to have incontinent episodes of the bladder, the following will be completed. 1. Complete the 3-day tracking form to help determine pattern of incontinence for suspected or known incontinence upon admission, onset of new incontinence, or quarterly, if change in incontinence is noted on MDS assessment. 2. Completed Bowel and</p>			

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	<p>Bladder Assessment on admission, quarterly, or when resident develops an incontinence problem. 3. Initiate/update plan of care to address alterations in bladder."</p> <p>The assessment for Resident #29's increased incontinence was not thoroughly assessed as there was a portion of the assessment incomplete, the 3 day tracking form utilized to determine toileting and voiding patterns was incomplete and did not provide enough completed information to be utilized, the care plan was not revised to address the resident's current status, and when the nursing assistant assignment sheet was updated, the information did not reflect the resident's current status.</p> <p>3.1-41(a)(2)</p>			

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F 329 SS=D Bldg. 00	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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 contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview, the facility failed to ensure there was adequate monitoring for antianxiety medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #34)</p> <p>Findings include:</p> <p>Resident #34 was observed, during the day time hours on 03/17/15 and 03/18/15, seated in his room in a recliner or in his wheelchair. The resident was often noted</p>	F 329	<p>Resident #34 has had care plan updated to include signs and symptoms of anxiety. Resident #34 has had care plan and Behavior Monitoring Flowsheets updated to reflect target behaviors. Resident #34 has had a Gradual Dose Reduction of the morning dose of Ativan on 1-4-15 and a reduction of the evening dose on 1-26-15.</p> <p>All residents with a diagnosis of anxiety, and receiving anti-anxiety medication, have had their care plans and Behavior</p>	04/17/2015

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	<p>to keep his eyes closed and sleep, did not speak and did not exhibit any symptoms of anxiety.</p> <p>The clinical record for Resident #34 was reviewed on 03/23/2015 10:25:47 AM. Resident #34 was admitted to the facility on 06/27/08 with diagnoses, including but not limited to, dementia with behavioral disturbances, Alzheimer's disease, mood disorders, adjustment disorder with depression, psychosis, constipation, peripheral vascular disease and depressive disorder.</p> <p>The current physician's orders for medication included orders for the resident to receive the anti-anxiety medication Lorazepam 0.5 mg (milligrams) at bedtime and 0.25 mg in the morning for "anxiety." The resident also had a physician's order to receive the antianxiety medication Atarax 10 mg at bedtime. The resident also received the antipsychotic/antiseizure medication, Divalproex 125 mg once a day to treat a diagnosis of Dementia with behavioral disturbances.</p> <p>The current behavioral monitoring for Resident #34, located in the Medication Administration Record book was for the behaviors of Resistive to care and Combativeness. The tracking form had</p>		<p>Monitoring Flowsheets reviewed and updated to ensure specific signs, symptoms and behaviors as well as appropriate interventions are addressed.</p> <p>1. Nursing and Social Service staff to be serviced regarding Behavior Assessment and Monitoring Policy, effective 4/15/15.</p> <p>2. Hubbard Hill Care Plan Policy will be reviewed with Nursing and Social Services staff, effective 4/15/15.</p> <p>3. All new admissions are to be reviewed by the Social Service Manager or designee to capture residents utilizing anti-anxiety medications. The Social Service Manager or designee will ensure that care plans reflect specific anxiety signs, symptoms and behaviors as well as appropriate interventions.</p> <p>4. The Unit Manager, or designee will forward copies of physician orders, on scheduled days of work, to the Social Service Manager/designee to capture newly ordered anti-anxiety medications. The Social Service Manager/designee will ensure that care plans reflect specific anxiety signs, symptoms, and behaviors as well as appropriate interventions.</p> <p>5. The Unit Managers will audit 5 non-assigned residents to assure care plans and Behavior Monitoring Flowsheets are</p>				

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	<p>both the Depakote (Divalproex) and Lorazepam medications listed on the form.</p> <p>The current health care plans for Resident #34 included a plan to address the resident's history of being physically abusive during care, a plan to address the potential side effects of the antianxiety medication use, and a plan to address the Depakote medication use to due Dementia with behavioral disturbances. There was no plan to address the resident's signs and/or symptoms of anxiety and no interventions to address the resident's anxiety.</p> <p>The antianxiety/hypnotic medication use care plan, initiated on 09/26/12 and reviewed on 03/12/15, indicated the resident had a diagnosis of anxiety and received Atarax and Lorazepam. The interventions were to provide medications as ordered, monitor for possible side effects from medication every shift using side effects monitoring flow sheet. Provide interventions and document prior to giving PRN medications, monitor lab work ordered, notify physician if interventions ineffective or side effects are noted. The dates and reduced medication doses of Depakote and Ativan were noted on the care plan but there were no specific</p>		<p>updated to include signs, symptoms and interventions for residents having a diagnosis of anxiety and using anti-anxiety medications. The Unit Manager will audit weekly x 4, bi-monthly x 2, then quarterly.</p> <p>Results of the Unit Manager audits will be reviewed weekly at the Clinical Management Meeting with the Director of Nursing/VP of Quality Management, and quarterly at the QA meeting x 2. At that time will review for continued need for auditing.</p>				

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	<p>behaviors related to anxiety or interventions to address the anxiety noted on the care plan. There was a monthly behavior monitoring flowsheet for the targeted behaviors of resistive care and combative and both Ativan and Depakote were noted on the psychoactive medication. There were 12 nonspecific interventions on the form to document. The resident had not exhibited either behavior in January, February or March 2015.</p> <p>During an interview on 03/23/15 at 11:32 A.M., the unit manager, RN #3, after she looked through the care plans, indicated she would contact another staff member " to check into that,"related to no care plan to address anxiety. During an interview, on 03/23/2015 at 1:56 P.M., RN #3, indicated they were still unable to locate a care plan related to the resident's anxiety.</p> <p>A care plan related to the resident's diagnosis of anxiety was initiated on 03/23/15. During an interview, on 03/23/2015 at 2:51 P.M., RN #3 indicated the resident exhibited his anxiety by becoming restless, rocking and scratching/rubbing his skin all over even though there was no rash or observed skin issue. The unit manager marked out "pacing" which was listed on the care</p>			

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F 371 SS=F Bldg. 00	<p>plan. There was no behavior monitoring for these behaviors on the behavior log form.</p> <p>On 03/24/15 at 10:30 A.M., the Director of Nursing presented a copy of a care plan related to Resident #34's history of becoming combative with care. The plan had various dose reductions for both the Depakote and Ativan medications noted on the plan. However, the plan did not address the resident's anxiety issues which he displayed by restlessness, rocking, and scratching. There was no other information given regarding the care plan.</p> <p>3.1-48(a)(3)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>			

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	<p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, record review, and interviews the facility failed to ensure food was prepared under sanitary conditions for 1 of 3 kitchens observed. This related to staff's inappropriate use of gloves and lack of handwashing during meal preparation. This had the potential to affect 59 of 59 residents who consumed food in healthcare. (Cook #4 and Cook #5)</p> <p>Findings include:</p> <p>During observation of food preparation and service in the main kitchen, conducted on 03/17/15 at 11:25 A.M., the following was noted:</p> <p>Cook #4 was observed grilling salmon filets. He was noted to not wash his hands, then handled the outside of a stainless steel bowl with salmon in it, the oven door where he checked on a piece of chicken, and then reached in the bowl with his bare hands, grabbed salmon fillets with his bare hands and placed them on the hot grill.</p> <p>In addition, Cook #5 was noted to have gloves on, carried a large stock pot of cooked potatoes to the counter holding the pan with both hands, dumped 1/2 of</p>	F 371	<p>Dietary food prep staff/cooks to be in-serviced on proper food handling, preparation and delivery effective 4/15/15.</p> <p>Dietary Management Team and Registered Dietitian (RD) will perform random audits observing food handling preparation and delivery in all dining areas.</p> <p>1. Dietary food prep staff/cooks to be in-serviced on proper food handling, preparation and delivery. Effective 4/15/15</p> <p>2. Dietary food prep staff/cooks to be in-serviced on proper hand washing. Procedure has been posted at hand washing stations. Effective 4/15/15</p> <p>3. Support Services Director or designee to audit food preparation in each of the (3) kitchens on scheduled days of work throughout the audit schedule noted on #4.</p> <p>4. Registered Dietitian (RD) to audit food handling, preparation and delivery weekly x 4/weeks, bimonthly x 2, and then quarterly to ensure proper technique.</p> <p>Results of Support Services Director/designee and Registered Dietitian audits to be discussed in Dietary Manager's meetings scheduled bi-weekly with the Administrator and presented to QA meeting quarterly x2. After the 2nd QA Meeting discussing the</p>	04/17/2015			

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	<p>the pot into a steam table pan and then took his contaminated gloved hand to spread out the potatoes touching the tops of the potatoes. He repeated this process with a second steam table pan of potatoes.</p> <p>During an interview with the Director of Food Service, Employee #6 and the head Cook/Chef, Employee #7, on 03/25/15 at 11:00 A.M., they both indicated the cook should have washed his hands between handling the salmon and handling other items. They indicated the other cook should not have touched the potatoes with his contaminated gloved hands. They presented the current policy, on 03/25/15 at 11:00 A.M., titled "Preventing Contamination From Hands," dated 09/09/2008, which indicated "Food employees shall not contact exposed, ready - to - eat food with hands that have not been washed...and shall use suitable utensils...Food employees shall minimize bare hand and arm contact with exposed food that is not in a ready-to-eat form." Employee #7 indicated although the policy referred to ready to eat foods it really should be followed for all food handling.</p> <p>3.1-21(i)(3)</p>		Dietary Compliance Audit Report it will be determined if thereis a need for further training and/or audits.	

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R 000  Bldg. 00	Hubbard Hill Estates was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 000			