

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/09/2015
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NAME OF PROVIDER OR SUPPLIER  HANOVER NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 2, 3, 4, 5, 6, and 9, 2015.</p> <p>Facility number: 000115 Provider number: 155208 AIM number: 100291080</p> <p>Survey Team: Tammy Forthofer, RN, TC Rita Bittner, RN Debra Holmes, RN (February 2 and 3, 2015) Julie Dover, RN (February 4, 5, 6 and 9, 2015)</p> <p>Census bed type: SNF/NF: 58 Residential: 7 Total: 65</p> <p>Census payor type: Medicare: 11 Medicaid: 40 Other: 7 Total: 58</p> <p>This deficiency reflects state findings</p>	F000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of this survey findings, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me.</p>	

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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F000241 SS=D	<p>cited in accordance with 410 IAC 16.2-3.1. in regard to the State Residential Survey.</p> <p>Quality review completed on February 15, 2015, by Janelyn Kulik, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure each resident's dignity was maintained related to: insufficient/soiled clothing for 3 of 3 residents reviewed for dignity of the 3 residents that met the criteria for dignity. (Resident #37, #71, &amp; #98)</p> <p>Findings include:</p> <p>1. On 02/03/2015 at 10:00 AM, Resident #37 was observed in the hallway wearing a white T-shirt with three, dry, red, dime size, circular, stains on the right lower abdomen area and two, nickel size, dry, red, stains on the upper left sleeve area. The resident's left white sock had a two inch by one inch, dry, red, stain on the toe of the sock.</p>	F000241	<p>F 241: Requires the facility to promote care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. Resident # 37 was offered to change and shower on 2/2/15 and refused. This was documented on a mood and behavior communication memo. Resident agreed on 2/4/15 that he would shower and changed. Resident #98 no longer resides in the facility. Resident #71 was asked if he was ok with his curtain being closed and he was agreeable. 2. In an effort to identify any other concerns, 100% audit of all current residents was completed there were no dignity concerns noted. 3. All residents have the potential to be affected, thus, the following corrective</p>	03/04/2015
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	<p>On 02/04/2015 at 2:09 PM, Resident #37 was observed lying in bed. The resident was wearing a white T-shirt with three visible dark, dry, red, dime size circular stains on the right lower abdominal area and two, nickel size, dark, dry, red, stains on the upper left sleeve area. The resident's left white sock had a two inch by one inch, dry, dark, red, stain on the toe of the sock.</p> <p>On 02/05/2015 at 8:56 AM, Resident #37 was observed in the hallway by the nurses' station wearing a white T-shirt with three visible dark, dry, red to black, dime size, circular, stains on the right lower abdominal area and two, nickel size, dark, dry, red to black, stains on the upper left sleeve area. The resident's left white sock had a two inch by one inch, dry, dark, red to black stain on the toe of the sock.</p> <p>During an interview on 02/05/2015 at 8:58 AM, with the Assistant Director of Nursing (ADON), she indicated all of the resident's clothing should be neat and clean. She further indicated if a resident's clothing became soiled, the staff should try to encourage the resident to change his or her clothing. If the resident refused to change their clothing, the Certified Nursing Assistant (CNA) should report</p>		<p>actions have been taken: All nursing staff in-serviced on the importance of dignity and the current policy and procedure for clothing. (See attachment A). As a means to ensure ongoing compliance, the DON or designee will monitor for compliance during daily rounds: daily times four weeks on scheduled work days, weekly times four weeks, monthly times two months then quarterly until compliance is maintained. (See Attachment B). 4. As a means of quality assurance, the aforementioned audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. Completion Date: March 4, 2015.</p>		

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	<p>the refusal to the nurse. The nurse should try to talk to the resident and if the resident continues to refuse the nurse was required to document the refusal in the nursing notes.</p> <p>The record for Resident #37 was reviewed on 02/05/2015 at 9:03 AM. The Care Plan for Activities of Daily Living (ADL) dated 12/29/2015, indicated the resident required one staff to assist with dressing.</p> <p>The "Resident Care Record" for Resident #37 was reviewed on 02/05/2015 at 9:10 AM. There were no documented refusals to change clothing indicated, by the resident, dated from 02/012015 to 02/05/2015.</p> <p>2. On 02/02/2015 at 11:40 AM, Resident #98 was observed in the therapy room and could be seen from the main hallway. The resident was standing at the parallel bars assisted by Physical Therapist Assistant (PTA) #2. The resident was wearing a white with blue print hospital gown with his back to the door. The back of the gown was open exposing the resident's incontinence brief. After three minutes, PTA #3 walked across the therapy room and closed the door.</p> <p>During an interview on 02/04/2015 at</p>			

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	<p>01:10 PM, Resident #98 indicated he likes to wear his robe or gown, as a robe, to cover his back side when in therapy. He indicated today during therapy the staff placed a second gown on to cover the opening in the back of his gown.</p> <p>During an interview on 02/04/2015 at 11:04 AM, Certified Occupational Therapy Assistant (COTA) #4 indicated when a resident was receiving therapy and not fully dressed, " We shut the door and make sure no other residents are in the room. We always encourage them to get dressed. "</p> <p>The record for Resident #98 was reviewed on 02/04/2015 at 11:05 AM. The Care Plan, dated 1/27/2015, indicated the resident required the assistance of one to two staff members to perform activities of daily living.</p> <p>3. On 02/04/2015 at 01:50 PM and 02:51 PM, Resident #71 was observed sleeping in bed with the bare skin of his buttocks visible from the hallway. The resident was wearing dark colored sweat pants with the waist band below his buttocks. The door to the resident's room was wide open and the privacy curtain was not pulled.</p> <p>On 02/05/2015 at 9:01 AM, Resident #71</p>				

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	<p>was observed sleeping in bed with his buttocks exposed and visible from the hallway.</p> <p>During an interview on 02/04/2015 at 1:52 PM, certified nursing assistant (CNA) #5 indicated Resident #71 " Needs a little assistance dressing, his clothing has been too large and falls down " .</p> <p>During an interview on 02/05/2015 at 9:03 AM, the Social Service Director (SSD) indicated he was aware of the clothing issues for Resident #71. He indicated some clothing was purchased for the resident, but the resident had refused to wear the clothing that would fit him properly.</p> <p>During an interview on 02/05/2015 at 9:05 AM, ADON indicated she was aware of Resident #71's clothing not fitting him properly. She indicated if staff see the resident exposed they should close the resident's door or pull the curtain to protect his privacy.</p> <p>During an interview on 02/05/2015 at 9:21 AM, the SSD indicated he had documented in the care plan of Resident #71 for the clothing size and refusal to wear other clothing purchased for him. He indicated he was aware of the</p>			

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F000279 SS=D	<p>resident's pants falling down while the resident was walking in the hallway, but he was not aware of the resident exposed while lying in bed.</p> <p>The record for Resident #71 was reviewed on 02/05/2015 at 9:25 AM. The Care Plan, dated 02/04/2015, for activities of daily living "ADL", indicated the resident required the assistance of one staff member with dressing.</p> <p>The current Policy and Procedure for clothing was provide by the DON on 2/5/2015 at 11:14 AM. Under "Guidelines for Changing the Residents' Clothing", the policy indicated to change the resident's clothing daily or as needed due to resident request or soiling. "Assist the resident to maintain a clean, attractive appearance to preserve the resident dignity and self-respect.</p> <p>3.1-3(t)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise</p>			

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	<p>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, interview, and, record review the facility failed to develop a care plan for urinary catheter use for 1 of 2 residents reviewed for urinary catheter use in a sample of 22 residents reviewed for care plans. (Resident #8)</p> <p>Findings include:</p> <p>During an interview on 02/04/2015 at 10:33 AM, Licensed Practical Nurse (LPN) #1 indicated there had been two attempts to remove the urinary catheter from Resident # 8 with no success. Resident #8 continues to have urinary retention.</p> <p>The clinical record for Resident #8 was</p>	F000279	F279: Requires the facility use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 1. Resident #8 plan of care has been updated to reflect the use of the catheter for urinary retention. 2. In an effort to identify all residents potentially affected, 100% audit of all current residents' with catheters care plans were reviewed. No other residents were affected. 3. As a means to ensure ongoing compliance, all nursing staff in-serviced on the importance of care plans being completed when a new order is received. (See attachment A). 4. As a means of quality assurance, the DON or designee will monitor for ongoing compliance with development of care plans. All new orders will be	03/04/2015	

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	<p>reviewed on 02/04/2015 at 9:50 AM. The last documented attempt at leaving the urinary catheter out was made on 01/24/2015. Resident #8 was unable to urinate and the urinary catheter was reinserted. Resident #8 had an appointment with the urologist on 02/04/2015.</p> <p>Physician orders dated 02/04/2015 indicated the urinary catheter was to be reinserted if Resident #8 was unable to void by 6:00 PM.</p> <p>Upon review of the care plans for Resident #8, there was a care plan for urinary incontinence but no care plan for urinary catheter use.</p> <p>The admission Minimum Data Set assessment (MDS) dated 01/22/2015 indicated Resident #8 had a urinary catheter. Diagnoses included but not were limited to, hypertension, urinary retention, atrial fibrillation, and chronic obstructive pulmonary disease.</p> <p>On 02/05/2015 at 9:30 AM, Resident #8 was observed with a urinary catheter and bed side drainage bag.</p> <p>16.2-3.1-35(a)</p>		<p>checked with appropriate care plans daily times four weeks on scheduled work days, weekly times four weeks, monthly times two months then quarterly until compliance is maintained. (Attachment B). The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. Completion date: March 4, 2015.</p>		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview and record review the facility failed to ensure Passive Range of Motion exercises were performed as care planned for 1 of 1 resident reviewed for passive range of motion of the 1 who met the criteria for range of motion. (Resident #19)</p> <p>Findings include:</p> <p>The record for Resident #19 was reviewed on 02/04/2015 at 10:15 AM. The Care Plan "ADL Assist Required" dated 10/14/2014 indicated the resident was to receive Passive Range of Motion (PROM) exercises as tolerated daily.</p> <p>The "Restorative Nursing" log sheet indicated the resident received PROM exercises on 9 days out of 31 days, for the month of October 2014. The dates included:</p>	F000282	F 282: Requires that services provided or arranged by the facility must be provided by persons in accordance with each resident's written plan of care. 1. Resident #19 care plan was updated on 2/24/15. 2. All residents have the potential to be affected, thus, the following corrective actions have been taken. 100% audit of all current residents' receiving PROM were reviewed and care plans updated. 3. As a means to ensure ongoing compliance with ensuring residents are receiving PROM all nursing staff in-serviced on the importance of passive range of motion exercise. (See attachment A). 4. As a means of quality assurance, the DON or designee will monitor for ongoing compliance with the PROM policy and procedure. DON or designee will review PROM records on scheduled work days, daily times four weeks on scheduled work days, weekly times four weeks,	03/04/2015			

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	<p>October 2, 2014 October 6, 2014 October 9, 2014 October 13, 2014 October 16, 2014 October 20, 2014 October 23, 2014 October 27, 2014 October 30, 2014</p> <p>The "Restorative Nursing" log sheet indicated the resident received PROM exercises on 10 days out of 30 days for the month of November, 2014. The dates included:</p> <p>November 4, 2014 November 6, 2014 November 11, 2014 November 13, 2014 November 18 2014 November 20, 2014 November 24, 2014 November 25, 2014 November 27, 2014 (both in the AM and PM) November 29, 2014</p> <p>The "Restorative Nursing" log sheet indicated the resident received PROM two times a day for 31 days out of 31 days for the month of December 2014.</p> <p>The "Restorative Nursing" log sheet indicated the resident received PROM</p>		<p>monthly times two months then quarterly until compliance is maintained. (See attachment B). Should concerns and/or non-compliance be noted, corrective action shall be taken. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted.</p> <p><b>Addendum:</b> Please note the aforementioned monitoring for compliance with the policy and procedure will include both observation of staff performance of PROM as well as documentation thereof. Said monitoring will occur as per the schedule listed, on varied shifts/times. Completion Date: March 4, 2015.</p>		

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F000309 SS=D	<p>two times a day for 31 days out of 31 days for the month of January 2015.</p> <p>During an interview on 02/05/2015 at 10:43 AM, the DON indicated Resident #19 had a care plan, dated 10/14/2015, for ADL's with the intervention of PROM daily as tolerated. The care plan was updated on 01/08/2015 with no changes noted.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review the facility failed to timely document non-pressure skin issues for 1 of 3 residents reviewed for skin conditions (non-pressure) of the 3 who met the criteria. (Resident #37)</p> <p>Findings include:</p> <p>On 02/03/2015 at 9:57 AM, Resident #37 was observed in his room with a small</p>	F000309	F309: Requires that 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. 1. It is the goal of the facility to provide services to its residents to allow the resident to attain or maintain their highest practicable physical and	03/04/2015

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	<p>scratch on his left upper arm. The resident's T-shirt had dried, red, stains on the left upper sleeve and lower abdomen. The resident's left sock also had a dried red stain.</p> <p>On 02/03/2015 at 10:00 AM, Resident #37 was observed in the hallway across from the nurses' station. The resident's T-shirt had dried, red, stains on the left upper sleeve, abdomen, and left sock.</p> <p>During an interview on 02/03/2015 at 9:58 AM, Resident #37 indicated he had scratched his left upper arm on his wheel chair in the middle of the night a couple of days prior.</p> <p>During an interview on 02/05/2015 at 9:34 AM, LPN #7 indicated skin assessments should be done as soon as possible after injuries or changes in skin condition.</p> <p>On 02/05/2015 at 11:19 AM during an interview with DON, she indicated the appropriate time frame for incident reporting and documentation was within 2 hours of the incident.</p> <p>Record review of the Incident Report, dated 2/3/15 and documented at 7:00 PM, indicated resident #37 had a small skin tear to the left arm above elbow. The</p>		<p>psychosocial well-being. Resident # 37 non-pressure skin issue was documented on 2/3/15. 2. All residents have the potential to be affected thus; the following corrective actions have been taken. 100% audit of all residents' skin was assessed and appropriate documentation is in place. No other areas of concern were identified. 3. In an effort to ensure ongoing compliance, licensed nursing staff have been in-serviced on the importance of documenting on all skin issues. (See attachment A). 4. As a means of quality assurance, the DON or designee will monitor for compliance by interviewing licensed nursing staff regarding skin assessments and skin documentation daily times four weeks on scheduled work days, weekly times four weeks, monthly times two months then quarterly until compliance is maintained on varying shifts. (See attachment B). Should concerns and/or non-compliance be noted, corrective action shall be taken. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted.</p> <p><b>Addendum:</b> Please note the aforementioned monitoring for compliance shall include visual inspection/assessment of</p>		

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F000315 SS=D	<p>Incident Report documentation indicated the resident received this scratch while transferring himself into the wheel chair on 02/03/2015 at 7:00 PM.</p> <p>The current Policy and Procedure for accidents was provide by the DON on 2/5/2015 at 11:14 AM. Under "Accident and Incident Reporting", the policy indicated the report form should be initiated as soon as possible following the incident.</p> <p>3.1-37(a)</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, interview, and record review, the facility failed to ensure there was medical justification for the use of a Foley catheter for 1 of 2 residents reviewed who met the criteria for Foley</p>	F000315	<p>resident skin following interview, in an effort to confirm ongoing accurate identification, documentation and monitoring in place. Completion Date: March 4, 2015</p> <p>F 315: Requires the facility to 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;</p>	03/04/2015

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	<p>catheter use. (Residents #14)</p> <p>Findings include:</p> <p>During an observation, on 02/03/2015 at 9:05 AM, it was noted that Resident #14 had a catheter bag hanging on the side of her bed, covered with a cloth bag. The resident was alert, oriented, and well groomed.</p> <p>An interview was conducted on 02/04/2015 at 1:51 PM with LPN (Licensed Practical Nurse) #9. She indicated the resident had a Foley catheter due to urinary retention. She further indicated the resident had "just a little" excoriation on her buttocks. Riley's butt cream was being used on her bottom. The resident was admitted with excoriation on her buttocks and it was an ongoing issue. LPN #9 indicated the resident was very private and refused to allow observation of Foley care, and buttock excoriation. LPN #9 also indicated the resident did not currently have a pressure ulcer.</p> <p>An interview was conducted on 02/04/2015 at 2:13 PM with the ADON (Assistant Director of Nursing). She indicated the resident had a Foley catheter due to urinary retention. She further indicated the resident had rectal</p>		<p>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. 1. Resident #14's PVR (post void residual) was ordered; however physician documents that if patient refuses the PVR that he will change the diagnosis for the Foley Catheter to terminal illness. 2. All residents have the potential to be affected thus; the following corrective actions have been taken. 3. Nurse management staff has been in-serviced on the federal regulation regarding Foley Catheters. (See attachment C). 4. As a means of quality assurance, new orders pertaining to catheterization will be reviewed daily times four weeks on scheduled work days, weekly times four weeks, monthly times two months then quarterly until compliance is maintained. (See attachment B). Should concerns and/or non-compliance be noted, corrective action shall be taken. The audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly, if warranted. Completion Date: March 4, 2015.</p>				

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	<p>cancer, loose stools often, and a pressure ulcer on admission. She indicated the doctor had discussed removing the Foley catheter with the resident and produced a document indicating such. The document was dated 03/05/2014.</p> <p>During an interview with the DON (Director of Nursing), on 02/09/2015 at 10:58 AM, she indicated the resident had not been seen by a urologist.</p> <p>During an interview on 02/09/2015 at 1:21 PM, the ADON indicated she could not find any consult for a urologist in the chart nor could she remember one ever being consulted.</p> <p>During an interview on 02/09/2015 at 11:05 AM, the ADON indicated the facility does not give catheters to everyone who wants one. The DON indicated this particular resident refused to try to urinate without the catheter. The DON further indicated the resident was frail and had diarrhea.</p> <p>During an interview on 02/06/2015 at 3:16 PM with the Administrator and Activities Director, they indicated the resident had constant loose stools.</p> <p>An interview was conducted on</p>						

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	<p>02/09/2015 at 3:06 PM with LPN #10.</p> <p>She indicated she performs bladder irrigations on the resident, as ordered by the doctor, to keep the catheter patent and reduce bacteria.</p> <p>The clinical record was reviewed on 02/06/2015 at 3:10 PM. The quarterly MDS (Minimum Data Set) assessment, dated 11/05/2014, indicated a BIMS (Brief Interview for Mental Status) score of 15, signifying the resident was alert and oriented. Diagnoses included but were not limited to anemia, hyponatremia, hypertension, anxiety, and insomnia. The resident also had a history of alcohol abuse, rectal cancer, and chronic diarrhea.</p> <p>The Care Plan, which was last updated on 11/19/2014, indicated, " The resident requires the use of a Foley catheter due to: Urinary retention and is at risk for infection. Anti-anxiety use, antidepressant use, pain, and unsteady gait were also listed on the Care Plan as part of the problem and reason for the use of the Foley catheter.</p> <p>Review of the Physicians Orders dated 01/20/2014 indicated "FOLEY CATH CARE EVERY SHIFT".</p>						

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	<p>Review of the Physicians Orders dated 03/04/2014 indicated "CHANGE 16 FR FOLEY CATH MONTLY ON THE 15TH DX: URINARY RETENTION"</p> <p>Review of the Physicians Orders dated 08/12/2014 indicated the diagnosis for the Foley catheter was urinary retention.</p> <p>Review of the Physicians Orders dated 11/18/2014 indicated "CHANGE FOLEY CATH URINARY DRAINAGE BAG WEEKLY ON MONDAYS".</p> <p>A urine culture lab report dated 11/10/2014 indicated the resident tested positive for a UTI (Urinary Tract Infection). The resident's urine tested positive for "Raoultella (K.) Orinthinolytica" greater than 100,000 parts per milliliter, and "Enterococcus Faecalis" (bacteria) with 70-99,000 parts per milliliter. On 11/12/2014 the doctor ordered Acetic acid, 0.25%, to be used to irrigate the bladder on Monday, Wednesday, and Friday "X" three doses and repeat the urine culture in two weeks. No antibiotics were ordered at that time.</p> <p>A doctor's order dated 12/20/2014, indicated a UA (Urine Analysis) was ordered due to the family's request. The UA was collected on 11/26/2014 and indicated no UTI was present.</p> <p>A urine culture dated 01/02/2015</p>			

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	<p>indicated the resident tested positive for a UTI with doctor's orders to "continue irrigation". No antibiotics were ordered. The resident's urine tested positive for Escherichia Coli (bacteria) greater than 100,000 parts per milliliter, and Gram Positive Cocci 50,000-100,000 parts per milliliter.</p> <p>The "Catheter Assessment" records were reviewed. The Admission assessment, dated 01/22/2014, listed the rationale for use of the catheter and diagnosis for the catheter as urinary retention. It further indicated the resident had not been evaluated by a Urologist in the past year or prior to the catheter insertion. Quarterly Re-Assessments were documented on 04/09/2014, 07/09/2014, and 10/30/2014. They indicated there were no changes in the resident's continence, the diagnosis for catheter use was urinary retention, and listed no date indicating the resident had been seen by a urologist. A Catheter Assessment was completed on 11/20/2014. The document did not signify whether the assessment was completed due to a significant change or if it was completed as the annual. The assessment indicated no changes from the admission order.</p> <p>Record review of the Progress Notes from the time of admission on</p>			

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F000318 SS=D	<p>01/20/2014 thru 02/06/2015 indicated the subject of the Foley catheter was address only one time in a note dated 03/05/2014. Listed under "Plan", the doctor indicated following a discussion with the resident, it "appears best to continue with catheter. This is both for history of urinary retention on chart and skin issues. If it appears skin issues not a problem then would want to monitor PVR (Post Void Residual) make sure retention problem better." There were no records indicating any attempt had been made to remove the catheter, therefore, no PVR was documented.</p> <p>3.1-41(a)(2)</p> <p>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, interview and record review the facility failed to ensure a resident received the necessary treatment and services to prevent further contractures for 1 of 1 residents reviewed for range of motion of the 1</p>	F000318	F 318: Requires the facility to ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1. Resident #19 receives PROM	03/04/2015			

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	<p>who med the criteria for range of motion. (Resident #19)</p> <p>Findings include:</p> <p>On 02/03/2015 at 10:24 AM, Resident #19 was observed in his wheel chair with only padding underneath his feet. The resident could not move his left or right leg without assistance.</p> <p>On 02/05/2015 2:00 PM, Resident #19 was observed in his wheel chair without splinting or padding between his lower extremities.</p> <p>On 02/09/2015 2:28 PM, Resident #19 was observed in his wheel chair without a splint or padding between his lower legs. The left leg was crossed and resting on the right leg.</p> <p>During an interview on 02/03/2015 at 10:26 AM, Resident #19 indicated he could not move his lower legs without assistance. He indicated he had not been able to feel his lower extremities for a very long time.</p> <p>During an interview on 02/04/2015 at 10:47 AM, the Certified Occupational Therapist Assistant (COTA), indicated Resident #19 was off of therapy 's case load. She indicated the resident was only</p>		<p>twice daily as tolerated; care plan was reviewed and updated on 2/24/15. Therapy will complete a screen and recommendations will be followed as written in the plan of care. 2. An audit of all other residents receiving PROM was completed. Therapy will complete screens and recommendations will be followed as written in the plan of care. 3. As a means to ensure ongoing compliance to ensure PROM completed, nursing staff were in-serviced on the PROM and following plan of care. (See Attachment A). 4. As a means of quality assurance, DON or designee will monitor the PROM documentation on work days daily times four weeks, weekly times four weeks, monthly times two then quarterly until compliance is maintained. Should non-compliance be observed, corrective action shall be taken. (See Attachment B). <b>Addendum:</b> Please note the aforementioned monitoring for compliance with the policy and procedure will include both observation of staff performance of PROM as well as documentation thereof. Said monitoring will occur as per the schedule listed, on varied shifts/times. Completion Date: March 4, 2015.</p>				

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	<p>receiving passive range of motion therapy from the CNA ' s at this time.</p> <p>The record for Resident #19 was reviewed on 02/04/2015 at 10:15 AM. The Care Plan "ADL Assist Required" dated 10/14/2014 indicated the resident was to receive Passive Range of Motion (PROM) exercises as tolerated daily.</p> <p>The "Restorative Nursing" log sheet indicated the resident received PROM exercises on 9 days out of 31 days, for the month of October 2014, 10 days out of 30 for the month of November, 2014.</p> <p>The "Restorative Nursing" log sheet indicated the resident received PROM two times a day for 31 days out of 31 days for the month of December 2014 and January 2015.</p> <p>During an interview on 02/05/2015 at 10:43 AM, the DON indicated Resident #19 had a care plan, dated 10/14/2015, for ADL's with the intervention of PROM daily as tolerated. The care plan was updated on 01/08/2015 with no changes noted.</p> <p>Review of the 10/01/2014 Annual Minimum Data Set (MDS) assessment, indicated the resident's Brief Interview for Mental Status (BIMS) score was 13,</p>			

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F000323 SS=D	<p>indicating he was alert and oriented. The resident was totally dependent on staff for bed mobility. He was "extensive assistance required" for personal hygiene and independent with locomotion once in his wheel chair off the unit. The resident had range of motion impairments to both sides of his lower extremities.</p> <p>Review of the 01/01/2015 Quarterly MDS assessment, indicated the resident 's BIMS score was 10, and he was alert and oriented. The resident was total dependency with full staff performance in, bed mobility, personal hygiene and locomotion of wheel chair off the unit. The resident had range of motion impairment on both sides of his lower extremities.</p> <p>3.1-42(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review the facility failed to determine the root cause of a fall and implement interventions in a</p>	F000323	F323: Requires the facility to ensure that the resident's environment remains as free of accident hazards as is possible;	03/04/2015			

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	<p>timely manner, related to wheel chair locking devices for 1 or 3 residents reviewed for accidents of 7 who met the criteria. (Resident #99)</p> <p>Finding includes:</p> <p>1. The record for Resident #99 was reviewed on 02/04/2015 at 09:59 AM. Nursing notes dated 1/27/2015 at 01:15 AM indicated the resident had yelled out "help". Staff responded and found the resident on the floor. The resident indicated; "Was trying to get into w/c (wheel chair), w/c rolled away, the brakes were not on, fell on the floor"</p> <p>The incident report dated 01/27/2015 for Resident #99 was reviewed on 02/06/2015 at 02:50 PM. The report indicated Resident #99 woke up and wanted to get up in her wheel chair. The resident attempted to transfer herself from the bed to the wheel chair. The wheel chair wheels were not locked. The wheel chair rolled away from the resident resulting in the resident landing on the floor.</p> <p>The Care Plan for Falls, dated 01/28/2015, was provided by the Director of Nursing on 02/02/2015 at 11:50 AM. The Plan indicated the resident had multiple risk factors for falls. The</p>		<p>and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident #99 fell on 1/27/15 and anti rollbacks were added to the wheelchair on the same day. 2. All residents have the potential to be affected thus; the following corrective actions have been taken. 3. As a means to ensure ongoing compliance with ensuring falls are reported to therapy timely, incident reports will be copied and supplied to therapy staff on next business day. Therapy manager will in-service staff to ensure a representative from therapy will be present for stand up meeting when manager is not in building. (See Attachment D). All licensed nursing staff will be in-serviced over finding the root cause of the fall. (See Attachment A). 4. As a means of quality assurance, the DON or designee will review incident reports to ensure appropriate root cause and intervention put in to place on work days daily times four weeks, weekly times four weeks, monthly times 2 then quarterly until compliance is maintained. (See Attachment B). Should noncompliance be observed, corrective action shall be taken. Results of the audits and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if</p>		

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	<p>interventions included to ensure that the resident was using assistive devices as indicated, such as a walker and wheel chair.</p> <p>During an interview on 02/04/2015 at 10:53 AM, the Certified Occupational Therapist Assistant (COTA), indicated she was not aware of Resident #99 falling on 01/27/2015. She indicated the resident was not listed on her "Morning Meeting" reports dated; 01/28/2015, 01/29/2015, and 01/30/2015. She indicated the morning meetings were used to communicate concerns from incident and accident reports indicating residents that needed to be assessed by the occupational therapy/ physical therapy (OT/PT) department related to accidents or injuries.</p> <p>During an interview on 02/04/2015 at 10:59 AM ,PTA #2 indicated nursing staff had not advised them of the resident's fall on 01/27/2105. He indicated the resident was observed on 01/30/2015, during her regular scheduled OT therapy appointment having trouble locking her wheel chair. The resident indicated to PTA #2 she was having trouble last week with locking her wheel chair. He indicated the resident's wheel chair was then fitted with handle extensions on 01/30/2015.</p>		warranted. Completion Date: March 4, 2015				

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F000425 SS=D	<p>On 2/5/15 at 11:21 a.m., Resident #99 was observed in her wheel chair. She was able to lock and unlock her wheel chair with the use of the handle extensions. the resident indicated she had no difficulties locking her wheel chair since she requested the handle extensions.</p> <p>3.1-45(2)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155208	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/09/2015
NAME OF PROVIDER OR SUPPLIER  HANOVER NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 W LAGRANGE RD HANOVER, IN 47243		
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	<p>Based on observation, interview and record review the facility failed to acquire medication refills in a timely manner for 1 of 32 medication administrations observed. (Resident #15)</p> <p>Findings Include:</p> <p>On 2/06/2015 at 3:14 PM, during an observation with LPN #8, Resident #15's Coreg medication card was empty and she was unable to administer the resident's medication.</p> <p>During an interview on 02/06/2015 at 3:15 PM, LPN #8 indicated the reorder sticker was removed from the card. She planned to fax a reorder request to the pharmacy and contact the physician concerning the missing dose of Coreg for Resident #8.</p> <p>During an interview on 02/09/2015 at 10:45 AM, the ADON and DON indicated medication reorder stickers were to be faxed prior the last 7 day supply of medication. The nursing staff were to remove the sticker and place it on the pharmacy reorder fax sheet. All reorder medication fax sheets were to be faxed into the pharmacy by the end of each shift.</p> <p>During an interview on 02/09/2015 at</p>	F000425	<p>F425: Requires the facility to provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described. 1. Resident #15 Coreg medication was ordered on 2/5/15. Resident # 15 medication arrived and receiving as ordered. 2. As all residents could be affected, the following corrective actions were taken. 3. As a means to ensure ongoing compliance, licensed nursing staff was in-serviced on the importance of our medication reordering policy on 2/24/15 and inserviced on the use of our back-up pharmacy should the physician believe it necessary to not miss a dose. (See Attachment A). 4. As a means to ensure quality assurance, the DON or designee will select 5 residents medication to review for proper reordering procedure on work days daily times four weeks, weekly times four weeks, monthly times 2 then quarterly until compliance is maintained. (See Attachment B). Should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. Completion Date: March 4, 2015.</p>	03/04/2015	

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R000000	<p>10:55 AM, the DON indicated no faxed request for Resident #8's Coreg was made prior to 03:00 PM on 02/05/2015.</p> <p>During an interview on 02/09/2015 at 11:42 PM, the pharmacy assistant at Innovative Pharmacy indicated Resident #8's Coreg was ordered on 02/05/2015 by fax.</p> <p>3.1-25(a)</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5.</p>	R000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of this survey findings, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus the facility respectfully requests the granting of paper compliance. Should</p>		

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R000247	<p>410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.</p> <p>Based on observation, record review and interview the facility failed to document a medication administration error for 1 of 28 medications observed. (Resident #2)</p> <p>Finding includes:</p> <p>During an observation of medication administration on 02/06/2015 at 11:00 AM, LPN #7 was observed to administered 11 different medications to Resident #2. The medications were counted and reviewed with the LPN #2 prior to administration to the resident.</p> <p>Record review on 02/06/2015 at 2:10 PM, of the physician medication orders for Resident #2 indicated the resident was scheduled to receive 12 medications at 11:00 AM. Prilosec 20 mg was scheduled to be given at 11:00 AM and was omitted.</p>	R000247	<p>additional information be necessary to confirm said compliance, please feel free to contact me.</p> <p>R 247: Requires the facility to note any error in medication administration in the resident's record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. 1. Resident # 2 prilosec medication was ordered on 2/6/15. Resident # 2 medication is being given per physician order. LPN #7 was in serviced on medication error policy and observed during a medication pass. (See attachment E). 2. As all residents could be affected, the following corrective actions were taken. 3. As a means to ensure ongoing compliance, licensed nursing staff was in-serviced on the importance of our medication error policy on 2/24/15 and inserviced on the use of our back-up pharmacy should the physician believe it necessary to not miss a dose. . (See attachment A). 4. As a means of quality assurance, the DON or</p>	03/04/2015

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	<p>An interview was conducted on 02/09/2015 at 9:58 AM with LPN #7. She indicated Resident #2's medication administration record indicated the resident should have received 12 medications on 02/06/2015 at 11:00 AM. LPN #7 indicated she documented the resident received her medication, Prilosec, by error and knew only 11 medication were administered on 02/06/2015. She indicated "I was nervous and missed the medication, Prilosec, for Resident #2".</p> <p>The current Policy and Procedure for medication errors provided by the DON on 2/9/2015 at 11:23 AM. Under "Medication Errors", the policy indicated..... #3 The Director of Nursing must be notified immediately upon discovery of a medication error... #6 Administrative nursing personnel shall investigate causal factors of medication error and shall initiate corrective action.</p>		<p>designee will randomly observe 1 medication pass during work days daily times four weeks, weekly times four weeks, monthly times 2 then quarterly until compliance is maintained. Should non-compliance be observed, corrective action shall be taken. (See Attachment B). The audits/monitoring and any corrective actions taken will be reviewed during the facility's quarterly Quality Assurance meetings and the plan of action adjusted accordingly if warranted. Completion Date: March 4, 2015</p>		