

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155570	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/23/2016
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NAME OF PROVIDER OR SUPPLIER PLEASANT VIEW LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7476 W LANE RD MC CORDSVILLE, IN 46055
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: February 17, 18, 19, 22, and 23, 2016</p> <p>Facility number: 000477 Provider number: 155570 AIM number: 100290860</p> <p>Census bed type: SNF/NF: 27 Total: 27</p> <p>Census payor type: Medicare: 3 Medicaid: 18 Other: 6 Total: 27</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on February 28, 2016.</p>	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a post survey paper compliance review on or after March 24 2016.	
F 0272 SS=D Bldg. 00	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and</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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	<p>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; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on observation, interview and record review, the facility failed to correctly code a Resident's quarterly Minimum Data Set (MDS) assessment for range of motion (ROM), for 1 of 3 residents reviewed for ROM of 6 who met the criteria for ROM. (Resident #27)</p>	F 0272	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#27's MDS was corrected to reflect her current medical condition. The MDS was corrected and transmitted on February 24, 2016.</p>	03/24/2016

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	<p>Findings include:</p> <p>Resident #27's record was reviewed on 2/19/16 at 11:53 a.m. Her diagnoses documented on her February 2016 physician's recapitulation orders included but were not limited to, advanced Huntington's disease and presenile dementia secondary to Huntington's disease with depression and delusions.</p> <p>Resident #27's quarterly MDS assessment dated 11/18/15, indicated she had no functional limitation in her ROM.</p> <p>Resident #27's Joint Mobility Assessment dated 1/9/16, indicated she had maintained her joint mobility since her assessment dated 7/15/15, and could not perform making a fist and fully opening her hand.</p> <p>A interview with MDS Coordinator #1 on 2/17/16 at 11:53 a.m., indicated Resident #27 had contracture's of both hands.</p> <p>On 2/17/16 at 12:02 p.m., Resident #27 was observed with her right hand fingers turned in toward her palm with 3 fingers touching her palm. Her thumb and first finger on her left hand were turned in toward her palm.</p>		<p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential for being affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An in-service will be held during the week of March 14-18, 2016 with the MDS Coordinator to ensure that each residents MDS is an accurate assessment. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place? The MDS Coordinator will monitor all MDS' for accuracy after each MDS is complete weekly x 3 months then monthly x 3 months. The QA Committee will review the results of her findings during the facility's Quality Assurance meeting for at least 6 months. At the end of the aforementioned 6 month period, the committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.</p>	

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F 0309 SS=D Bldg. 00	<p>On 2/19/16 at 11:19 a.m., Resident #27 was observed lying in bed. She had hand splints on both hands.</p> <p>An interview with MDS Coordinator #1 on 2/23/16 at 12:22 p.m., indicated Resident #27's quarterly MDS assessment dated 11/18/15, was marked incorrectly for ROM. Resident #27 had limited ROM in both of her hands.</p> <p>3.1-31(a) 3.1-31(c)(4)</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 thoroughly assess and document a resident's skin condition and implement interventions to reduce or prevent skin bruises and scratches for 1 of 3 residents reviewed for non-pressure related skin conditions of 6 who met the criteria for non-pressure related skin conditions. (Resident #27)</p>	F 0309	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident#27's skin records and nursing care plan have been updated to reflect their current skin condition and interventions are in place to reduce or prevent non-pressure skin condition. Resident#27 has a new doctor's order to place the bed against the wall so that when</p>	03/24/2016

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	<p>Findings include:</p> <p>Resident #27's record was reviewed on 2/19/16 at 11:53 a.m. Her diagnoses documented on her February 2016 physician's recapitulation orders included but were not limited to, advanced Huntington's disease, presenile dementia secondary to Huntington's disease with depression and delusions, and chronic anxiety.</p> <p>Resident #27's quarterly MDS assessment dated 11/18/15, indicated she was moderately impaired in her cognitive daily decision making skills. She required extensive assistance of 1 person for bed mobility, dressing, personal hygiene, and toileting. She required total assistance of 2 persons for transfer.</p> <p>A Non-Decubitus Skin Conditions assessment for Resident #27 dated 2/3/16, indicated she had a 2 centimeter (cm) by 2 cm reddish yellow bruise above her left knee that resolved on 2/9/16. She had scabs on both sides of her right knee from scratching that resolved on 2/16/16.</p> <p>A Non-Decubitus Skin Conditions assessment for Resident #27 dated 2/18/16, indicated she had 6 cm by 5 cm</p>		<p>the resident is up in the chair their legs are not within reach of the bed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? Only two residents have the potential for being affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An in-service on assessing, documenting and implementing interventions to reduce or prevent skin bruises or scratches was held March 10-11, 2016 for all charge nurses. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place? Charge nurses will assess and document all resident's skin for non-pressure related skin conditions. If new skin conditions are found the charge nurse will assess and implement all interventions daily x 14 days then weekly x indefinitely. DON or her designee will monitor the skin records for completion to ensure interventions and the nursing care plan are in place daily x 14 days then weekly x indefinitely. The QA committee will review the results of the findings during the facility's Quality Assurance</p>				

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	<p>faded bruise on her left lower extremity close to her ankle. She had a 11 cm x 4 cm faded bruise below her left lower extremity below her knee. She had a 7 cm x 3 cm faded red area on her right lower leg below her knee.</p> <p>A Plan of Care for Resident #27 initiated 2/18/16, indicated she had a problem with bruising below her left knee, below her right knee, and close to her left ankle. Her goal indicated she would heal without complications within 60 days. Her approaches indicated her skin would be assessed per protocol. She would receive fluids per protocol. The MD would be notified for pain or increased size.</p> <p>On 2/17/16 at 12:09 p.m., Resident #27 was observed reclined back in a cloth geriatric chair covered with wool type material. Her chair was positioned next to her bed. Her lower legs and feet were visible. She propped her legs on the bed mattress and she had movement with her legs, kicking them around. She had scabbed and discolored areas along her left shin and discoloration along her right shin.</p> <p>On 2/19/16 at 9:58 a.m., Resident #27 was observed reclined back in a cloth geriatric chair covered with a wool type</p>		meetings for at least 6 months. At the end of the aforementioned 6 month period, the committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.		

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	<p>material. Her chair was positioned next to her bed. Her lower legs and feet were visible. She was wearing socks. She had movement with her legs, kicking them around and at times placing them on her bed mattress. She had scabbed and discolored areas along her left shin. She had a discolored area below her right knee.</p> <p>On 2/22/16 at 10:23 a.m., Resident #27 was observed reclined back in a cloth geriatric chair. Her chair was positioned next to her bed. She had scabbed areas along her left shin with some light discoloration. She had a light discolored area below her right knee. She had movement with her legs, kicking them around.</p> <p>An interview with MDS Coordinator #1 on 2/22/16 at 2:04 p.m., indicated Resident #27 was hot natured and that is why the facility had not provided Resident #27 with leg protectors. Resident #27 wore Capri's all year long and that is why her legs were always visible. Resident #27 scratched herself, causing the scabs along her shins. She believed Resident #27 was possibly bumping her legs on her bed frame when her bed was raised and she was in her geriatric chair. She had told staff verbally to make sure Resident #27's bed</p>			

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	<p>was lower than her geriatric chair when she was up in her chair. She had not sent out a memo yet or placed the intervention on Resident #27's Plan of Care. She could not think of any other interventions to protect Resident #27's extremities.</p> <p>On 2/23/16 at 10:23 a.m., Resident #23 was observed reclined back in her geriatric chair. Her chair was positioned approximately 12 inches away from her bed. Her bed was in high position. She had movement with her legs, kicking them around.</p> <p>On 2/23/16 at 11:24 a.m., Resident #23 was observed reclined back in her geriatric chair. Her eyes were closed and she was positioned slightly on her right side facing her bed. Her bed was in high position.</p> <p>A Care of Skin Tears - Abrasions and Minor Breaks policy and procedure provided by Social Services on 2/23/16 at 11:16 a.m., indicated the following: "The purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin... Documentation - Record the following information in the resident's medical record: 1. Complete in-house investigation of causation. 2. Generate "Non-Pressure" form... 6. Any</p>			

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F 0514 SS=D Bldg. 00	<p>complications related to the abrasion (e.g., pain, redness, drainage, swelling, bleeding, decreased movement). 7. If the resident refused the treatment, the reason for refusal and the resident's response to the explanation of the risks of refusing the procedure, the benefits of accepting and available alternatives. 8. Interventions implemented or modified to prevent additional abrasions (e.g., clothes that cover arms and legs)...."</p> <p>3.1-37(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on observation, interview and record review, the facility failed to document when restorative ambulation was not completed for a resident, and why it wasn't completed for 1 of 20 residents reviewed for complete and</p>	F 0514	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All nursing personnel were in-serviced on ensuring proper documentation on the	03/24/2016

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	<p>accurate documentation. (Resident #34)</p> <p>Findings include:</p> <p>Resident #34's record was reviewed on 2/19/16 at 10:12 a.m. Her quarterly Minimum Data Set assessment dated 12/16/15, indicated her diagnoses included but were not limited to, dementia and hypertension. She was understood and had the ability to understand others. She was severely impaired in her daily decision making skills. She required extensive assistance of 1 person to walk in her bedroom and corridor. She utilized a walker and a wheelchair for mobility.</p> <p>A PT - Therapist Progress and Discharge Summary for Resident #34 dated 7/10/15, indicated she planned to be on a restorative therapy program for ambulation.</p> <p>An ambulation Plan of Care for Resident #34 dated 1/6/16, indicated Resident #34's goal would be to ambulate 150 feet daily times 90 days. Her approaches indicated her goal would be explained. She would be provided materials as needed. She would be assisted with the use of a walker and gait belt. She would refuse at times.</p>		<p>nursing restorative logs. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents that have a restorative program have the potential for being affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? An in-service will be held for the nursing department during March 10-14, 2016 on proper documentation for the nursing restorative log. A new nursing restorative log will be created to include a description if the resident refuses to participate or any other reason not to participate in the program. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance will be put into place? The DON or her designee will monitor the restorative program daily x 14 days then weekly x 5½ months. The QA Committee will review the results of her findings during the facility's Quality Assurance meeting for at least 6 months. At the end of the aforementioned 6 month period. The committee may opt to discontinue the review of this data during the QA meetings if compliance is evident.</p>	

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	<p>Resident #34's January 2016 and February 2016 Monthly Nursing Restorative Logs indicated she had not participated in her ambulation program on 1/1/16, 1/2/16, 1/3/16, 1/4/16, 1/5/16, 1/6/16, 1/8/16, 1/9/16, 1/10/16, 1/11/16, 1/13/16, 1/14/16, 1/15/16, 1/16/16, 1/17/16, 1/18/16, 1/19/16, 1/20/16, 1/21/16, 1/22/16, 1/23/16, 1/24/16, 1/25/16, 1/27/16, 1/28/16, 1/29/16, 1/30/16, 1/31/16, 2/1/16, 2/2/16, 2/3/16, 2/5/16, 2/6/16, 2/7/16, 2/10/16, 2/11/16, 2/12/16, and 2/16/16. No explanation was documented as to why Resident #24 had not participated in her ambulation program.</p> <p>On 2/18/16 at 1:30 p.m., Resident #34 was observed ambulating the hallway with the use of a rolling walker and the assistance of CNA #2 and CNA #3 with the use of a gait belt. CNA #2 was holding onto the gait belt around Resident #34's waist and CNA #3 followed behind Resident #34 closely with a wheelchair. Resident #34 was cooperative with ambulating and voiced no complaints.</p> <p>An interview with MDS Coordinator #1 on 2/22/16 at 1:39 p.m., indicated Resident #34 refused to participate in her ambulation program on the days the documentation was left blank on her</p>			

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	<p>Monthly Nursing Restorative Logs. She indicated no documentation was available Resident #34 had refused to participate in her ambulation program.</p> <p>An interview with CNA #4 on 2/23/16 at 9:52 a.m., indicated Resident #34 was on an ambulation restorative program. She indicated Resident #34 would refuse sometimes but would often participate and would walk pretty far. If Resident #34 refused to participate she would be re-approached later and encouraged to participate. If Resident #34 continued to refuse to participate on day shift, the information would be communicated to evening shift staff. She indicated she would document in Resident #34's restorative notes Resident #34 had refused to participate.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			