

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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F000000	<p>This visit was for the Recertification and State Licensure Survey. Survey dates: June 16, 17, 21, 22, 23, 2014 Facility number: 000314 Provider number: 155478 AIM number:100274210</p> <p>Survey team: Sylvia Scales, RN TC Dorothy Watts, RN Terri Walters, RN Amy Wininger, RN</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census payor type: Medicare: 15 Medicaid: 47 Other: 18 Total: 80</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 29, 2014 by Jodi Meyer, RN</p>	F000000	Requesting face to face IDR as we disagree with the scope and severity of F314.	

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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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 medications were administered according to the physician's order, in that, insulin was not administered as ordered by the physician for 1 of 5 residents who met the criteria for review of unnecessary medications (Resident #42) and a diuretic was not administered as ordered by the physician for 1 of 12 residents reviewed during medication administration pass. (Resident #49)</p> <p>Findings include:</p> <p>1. Resident #42 was observed on 07/16/14 at 12:02 P.M., sitting in a chair in the rehabilitation dining room.</p> <p>The clinical record of Resident #42 was reviewed on 07/22/14 at 10:19 A.M. The record indicated the diagnoses of Resident #42 included, but were not limited to, Insulin Dependent Diabetes Mellitus.</p> <p>The July 2014 Physician's Order Recap included, but was not limited to, orders</p>	F000282	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on August 12, 2014.</p> <p>F282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The residents affected by the alleged deficient of practice resident #42 and #59 have had orders clarified by the physician and corrected. Resident #42 and Resident #59 care plan has been updated per physician order.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	08/12/2014			

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	<p>for "...Accuchecks (test to measure blood glucose) (AC) before meals and at bedtime...Novolog (a fast-acting insulin) ...Inject subq (subcutaneous) per sliding scale before meals and at bedtime: 71-150 0 units 151-200 1 unit 201-250 2 units 251-300 3 units 301-350 4 units 351-400 5 units >400 call Dr. ..."</p> <p>The Capillary Blood Glucose Monitoring Tool indicated Resident #42 received Novolog insulin as follows:</p> <p>On 07/01/14 at 8:00 P.M.: 4 units for AC result of 300. (administration of 3 units indicated per sliding scale) On 07/04/14 at 11:30 A.M.: 4 units for AC result of 255 (administration of 3 units indicated per sliding scale) On 07/06/14 at 4:00 P.M.: 4 units for AC result of 204 (administration of 2 units indicated per sliding scale) On 07/08/14 at 4:30 P.M.: 4 units for AC result of 242 (administration of 2 units indicated per sliding scale) On 07/08/14 at 8:00 P.M.: 0 units for AC result of 233 (administration of 2 units indicated per sliding scale) On 07/09/14 at 7:00 A.M.: 3 units for AC result of 198 (administration of 1 unit</p>		<p>·All residents have the potential to be affected by the alleged deficient practice. DNS/Nurse managers /Designee performed an audit on all medication administration records on every current resident and new admissions and address any concerns per protocol. ·DNS/Licensed Nurse/Designee will perform a daily audit of residents with physician orders requiring insulin sliding scale.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ·Education on insulin sliding scale and medication administration has been provided to nursing staff by DNS/DNSS/Designee by August 11, 2014 ·Documentation review will be conducted by DNS/Designee daily and be performed by DNS/nurse managers/designee to ensure monitoring of residents with insulin sliding scale according to care plan and any issues will be immediately reported to ED/DNS/Nurse manager /Designee for appropriate follow up. ·DNS/Charge nurse/designee daily will conduct rounds to ensure per plan of care/physician orders are followed regarding medication administration each shift.</p> <p>How the corrective action(s) will be monitored to ensure the</p>	

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	<p>indicated per sliding scale) On 07/16/14 at 7:00 A.M.: 1 unit for AC result of 242 (administration of 2 units indicated per sliding scale) On 07/17/14 at 7:00 A.M.: 0 units for AC result of 169 (administration of 1 unit indicated per sliding scale) On 07/19/14 at 11:00 A.M.: 1 unit for AC result of 107 (administration of 0 units indicated per sliding scale) On 07/21/14 at 11:15 A.M.: 1 unit for AC result of 204 (administration of 2 units indicated per sliding scale)</p> <p>A Care Plan for "Resident is at risk for adverse effects of hyperglycemia or hypoglycemia related to use of glucose lowering medication and/or diagnosis of diabetes mellitus" dated 05/22/14 included, but was not limited to, interventions of "...Medications as ordered..."</p> <p>A lab specimen report for HgbA1C (a test to measure average blood sugar over the previous 90 days) dated 07/14/14 indicated a high result of 9.4 % on a reference range of 4.0-6.0%</p> <p>During an interview on 07/22/14 at 12:00 P.M., the DON (Director of Nursing) indicated insulin should be administered according to the sliding scale ordered by the physician.</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·DNS/Nurse managers/Designee will round daily using medication administration/insulin sliding scale CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place according to care plans.</p> <p>·If a threshold of 100% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p> <p>Compliance date: August, 11 2014</p>	

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	<p>2. During an observation of medication administration pass for Resident #59 on 07/23/14 at 7:15 A.M., RN #5 indicated a discrepancy was discovered, at that time, between the MAR (Medication Administration Record) and the pharmacy label for Torsemide (a diuretic medication). RN #5 further indicated, at that time, the MAR indicated Resident #59 should receive one tablet of Torsemide twice daily and the medication label indicated Resident #59 should receive two tablets of Torsemide twice daily.</p> <p>The clinical record of Resident #59 was reviewed on 07/23/14 at 7:30 A.M. The record indicated the diagnosis of Resident #59 included, but were not limited to, chronic renal failure.</p> <p>The June 2014 Physician Order Recap included, but was not limited to, an order for "...Torsemide 20 mg (milligrams) two tabs BID (twice daily)..."</p> <p>A Physician's Progress Note dated 06/25/14 indicated Resident #59 should receive "Torsemide 20 mg 2 (two tabs) twice daily for fluid and blood pressure..."</p> <p>The July 2014 Physician Order Recap</p>			

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	<p>included, but was not limited to, an order dated 06/20/14 for, "...Torsemide (a diuretic medication) 20 mg take 2 (two) tablet (sic) twice daily..."</p> <p>The July 2014 MAR indicated an entry for, "Torsemide 20 mg take (unreadable) tablet twice daily...". The number of tablets in the entry was obliterated and an undated handwritten notation of "1" was written to the right side of the entry. The MAR indicated Resident #59 received one 20 mg Torsemide twice daily from 07/01/14 through 07/22/14.</p> <p>During an interview on 07/23/14 at 9:45 A.M., RN #5 indicated she did not know when the entry was changed on the MAR.</p> <p>A Medication/Treatment Error Report dated 07/23/14 indicated Resident #59 received the wrong dose of Torsemide for an unknown time period.</p> <p>A Clarification Telephone Order dated 07/23/14 indicated Resident #59 should have been receiving "Torsemide 20 mg 2 tabs by mouth (40 mg) BID (twice Daily) d/t (due to) edema..."</p> <p>A Care Plan dated 06/20/14 for Fluid Maintenance included, but was not limited to, interventions of, "Administer</p>			

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F000314 SS=G	<p>medications as ordered..."</p> <p>During an interview on 07/23/14 at 3:30 P.M. the DON (Director of Nursing) indicated the entry was altered on or about 07/01/14. The DON further indicated, at that time, the dosage of the Torsemide should not have been changed without a physician's order.</p> <p>3.1-35(g)(1)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview, and record review, the facility failed to ensure a resident admitted without pressure areas developed pressure areas, in that, a resident identified to be at high risk for developing pressure developed wounds to</p>	F000314	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests</p>	08/12/2014

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	<p>the ankle and hand for 1 of 2 residents reviewed for Pressure ulcers. This deficient practices resulted in the Resident #40 developing unstageable pressure ulcers to the right outer ankle and to the right hand. (Resident #40)</p> <p>Findings include:</p> <p>The clinical record for Resident #40 was reviewed on 7/21/14 at 1:30 P.M. The record indicated the diagnoses of Resident #40 included, but were not limited to, fracture of the metacarpal bone right hand, Alzheimer's disease with behaviors, anemia, dementia, depression.</p> <p>The Admission MDS (Minimum Data Set Assessment) dated 05/28/14 indicated Resident #40 was at risk for developing a pressure ulcer, experienced severe cognitive impairment and needed the extensive assistance of 2 staff for ADL's.</p> <p>The Nursing Admission Assessment dated 5/21/14 indicated Resident #40 had no skin impairments upon admission and had a splint on his right hand for a fractured bone in his 5th finger.</p> <p>Lab reports dated 5/30/14 documented Resident #40's albumin level low at 3.2 g/dl. (normal range for albumin is 3.5 g/dl to 5.0 g/dl).</p>		<p>that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a face to face IDR in lieu of a Post Survey Revisit on August 12, 2014.</p> <p>F314 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>·The resident affected by the alleged deficient of practice resident #40 has been permanently discharged.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>·All residents have the potential to be affected by the alleged deficient practice. DNS/Nurse managers /Designee performed at risk for skin breakdown assessment on every current resident and new admissions and address any concerns per protocol. ·MDS coordinator/designee has reviewed all residents care plans to ensure monitoring was provided per plan of care regarding at risk for skin breakdown and will assess each new resident and create care plan for at risk for skin breakdown. ·MDS coordinator/designee will review all residents and new admissions with splints/casts/or</p>				

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	<p>Lab reports dated 6/5/14 documented Resident #40's albumin level low at 2.3 g/dl and his protein level low at 5.0 g/dl (normal range for protein is 6.3 g/dl to 8.2 g/dl).</p> <p>Nurses' progress notes dated 5/31/14 at 2:02 A.M. indicated that, "...while doing 12 am bed check, staff changing resident and turning and repositioning, area noted to right outer ankle..."</p> <p>A Pressure Wound Skin Evaluation Report dated 5/31/14 for the unstageable pressure area on the right outer ankle read as follows: "necrotic/eschar (Black, brown or tan tissue adheres to wound bed)...measurements...1 cm (centimeters) by 1.3 cm"</p> <p>The 9th Edition of Lippincott Manual Nursing Practice provided by the facility on 7/23/14 at 12:00 P.M., identified an unstageable pressure area as: "full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed."</p> <p>A Physician's order dated 5/29/14 read as follows: "...4. Pressure relieving boots to feet while in bed."</p> <p>The Treatment Administration Record (TAR) dated 5/29/14 through 5/31/14</p>		<p>removable braces to have appropriate care plans in place and physician orders to reflect the care required for such devices.</p> <ul style="list-style-type: none"> ·Licensed Nurse/DNS/Designee will perform skin care every shift to residents with splints and document every shift regarding care and/or abnormal findings. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Education on skin care, wounds and splint care has been provided to nursing staff by DNS/CEC/Designee by August 11, 2014 ·Documentation review will be conducted by DNS/Designee daily and be performed by DNS/nurse managers/designee to ensure monitoring of residents with at risk for skin breakdown according to care plan and any issues will be immediately reported to ED/DNS/Nurse manager /Designee for appropriate follow up. ·Staff will utilize skin management policy to ensure residents are monitored according to care plan. ·DNS/Charge nurse/designee daily will conduct rounds to ensure residents are monitored per plan of care for skin care concerns. ·Licensed Nurse/DNS/Designee will perform skin assessments weekly if concerns noted, physician will be notified and care plan updated <p>How the corrective action(s) will</p>		

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	<p>read as follows: "Pressure relieving boots to bilateral feet while in bed." The TAR documented nurses had signed and circled for the 29th (circled initials indicated the treatment was not administered to the resident at that time). Documented on the back of the TAR for 5/29/14 was the following notation: "boots not available."</p> <p>Physician's order dated 6/2/14 read as follows: "...2. bilateral pressure relieving boots to feet at all times. May remove for hygiene, skin checks and PRN (as needed)..."</p> <p>The Treatment Administration Record (TAR) dated 6/1/14 through 6/30/14 read as follows: "...bilateral pressure relieving boots to feet at all times may change for hygiene, skin checks and prn. "</p> <p>Documentation on the TAR indicates the boots were applied starting on 6/3/14 on the 2-10 shift.</p> <p>A care plan dated 5/21/14 read as follows: "Problem ...Resident is at risk for skin breakdown...Goal...Resident will be free from skin breakdown...Approach...Approach start date 5/29/14 Pressure relieving boot to bilateral feet while in bed...Discipline...CNA, Nursing..."</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·DNS/Nurse managers/Designee will round daily using skin management CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place according to care plans.</p> <p>·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p> <p>Compliance date: August 11, 2014</p>				

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	<p>A care plan dated 5/23/14 read as follows: "Problem...pressure area to right outer ankle, and pressure area to right hand inner aspect between thumb and wrist caused from splint that has been d/c'd...Approach start date: 5/27/14... pressure area to right outer ankle, and pressure area to right hand inner aspect between thumb... Approach start date 6/5/14 ROHO cushion Approach start date 6/5/14 Pressure relieving boots to bilateral feet while in bed..."</p> <p>During an interview with the DON on 7/23/14 at 10:35 A.M., the DON indicated that the Physician's order for the pressure relieving boots dated 5/29/14 was not transferred to the Treatment Administration Record until 6/3/14 when the new order for the pressure relieving boots was received.</p> <p>The facility's Policy and Procedure for Skin Management Program dated 6/20/12 was reviewed on 7/23/14 at 3:00 P.M., and read as follows: "...Procedure: ...Pressure reducing devices are to be put in place immediately...The care plan will be initiated to include specific alterations in skin integrity...The care plan will be initiated/revised addressing any new areas..."</p> <p>A Physician's order dated 5/27/14 read as</p>			

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	<p>follows: "Pt (patient) to be provided with R (right) 4th and 5th digit immobilization splint and stockinette placed over top to decrease risk of further injury. Pt to don at all times except for hygiene and per pts tolerance."</p> <p>Occupational Daily Treatment Notes dated 5/28/14 at 10:43 A.M., read as follows: "...patient did not have any assistive device and/or protection to R (right) hand this date. Nursing staff unable to locate and was unsure when device was removed. Therapist reapplied fabricated ulnar gutter splint to protect skin integrity and joint alignment of the 4th and 5th digits...Patient had not removed - 4 hours after therapist donned. Nursing to clarify orders and contact ortho MD in regards to pt non compliance with splint. Patient 5th digit volar splint cannot be found by nursing staff or this therapist..."</p> <p>Occupational Daily Treatment Notes dated 5/30/14 at 10:59 A.M., read as follows: "Caregiver training of orthotic application for R (right) hand/wrist. Strap for 4th and 5th digit was missing, and ulnar gutter portion of splint was placed on medial side of forearm/wrist versus radial side. Provision of padded cover to position over patient R hand to ensure device stays properly in place to</p>			

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	<p>provide pt (patient) with more protection.</p> <p>Nurse's progress notes dated 6/1/14 at 2:52 A.M. read as follows: "during bed check this nurse removed splint to right hand to clean and check skin. area noted to inner aspect of right hand b/t (between) the thumb and wrist area...scant amount of bloody drainage noted. 60% of area is scabbed, other 40% has red wound bed with yellow/white tissue in color... area tender to touch..."</p> <p>A Pressure Wound Skin Evaluation Report dated 6/1/14 for the unstageable pressure area on the right inner aspect b/t thumb and wrist read as follows: "...necrotic/eschar (Black, brown or tan tissue adheres to wound bed)...measurements...3 cm (centimeters) by .8 cm..."</p> <p>A Pressure Wound Skin Evaluation Report dated 6/5/14 for the unstageable pressure area on the right inner aspect b/t thumb and wrist read as follows: "...measurements..1.3 by 2.6.(cm)..."</p> <p>Occupational Daily Treatment Notes dated 6/2/14 at 11:25 A.M. read as follows: "...Patient has new area on medial surface of R (right) hand with nursing staff reporting that hand orthotic</p>			

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	<p>was removed to maintain integrity of skin. Therapist clarified that if splint was properly donned, that splint would not have caused skin breakdown..."</p> <p>The Medication Administration Record dated 5/23/14 through 5/31/14 read as follows: "Pt (patient) to be provided with r (right) 4th and 5th digit immobilization and stockinette placed over top to decrease further injury. PT (patient) to don at all times except for hygiene (sic) per pt's tolerance..."</p> <p>The TAR dated 6/1/14 through 6/30/14 read as follows: "...Splint for R (right) hand fx (fracture) X (times) 2 weeks...6-2 (6 A.M. to 2 P.M.) 2-10 (2 P.M. to 10 P.m.) 10-6 (10 P.M. to 6 A.M.)...D/c'd 6/4/14..."</p> <p>A care plan dated 5/21/14 read as follows: "...Problem ...Resident is at risk for skin breakdown...Goal...Resident will be free from skin breakdown..." Documentation was lacking in regard to interventions related to the pressure area on the right hand.</p> <p>A care plan dated 5/27/14 read as follows: "Problem... pressure area to right hand inner aspect between thumb and wrist caused from splint that has been d/c'd....Approach start date:</p>			

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	<p>5/27/14...pressure area to right hand inner aspect between thumb..." Documentation was lacking in regard to interventions related to the pressure area on the right hand.</p> <p>During an interview with the PTA on 7/22/14 at 2:07 A.M. the PTA indicated the pressure area on Resident #40's right hand was caused by the splint that was placed on 5/27/14. The PTA further indicated that after Physical Therapy placed the splint on Resident #40, they educated the staff on how to remove and replace the splint and how to monitor the resident's skin integrity.</p> <p>During an interview with the Health Care Administrator (HCA) on 7/22/14 at 2:50 P.M., the HCA indicated the facility did not have a policy for monitoring skin or splint use, only a procedure for care of splints. The HCA provided the facility's procedure and it read: "SPLINTS, BRACES, ORTHOTICS...Procedure...</p> <p>During an interview with the Director of Nursing (DON) on 7/22/14 at 2:30 P.M., the DON indicated Resident #40's medical record lacked documentation that his right hand splint placement and skin integrity had been monitored by nursing. She further indicated the care plan had not been updated to include new</p>			

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	<p>interventions for the area on the hand and the right ankle.</p> <p>The facility's Policy and Procedure for Skin Management Program dated 6/2012 read as follows: "...Procedure: ...Pressure reducing devices are to be put in place immediately....The care plan will be initiated to include specific alterations in skin integrity....The care plan will be initiated/revised addressing any new areas..."</p> <p>During an interview on 7/23/14 at 2:39 P.M., the DON, the PTA and the Corporate Clinical Specialist, all indicated no new documentation could be provided to indicate Resident #40 received skin assessments r/t splint use between night shift on 5/31/14 and night shift on 6/1/14.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>						

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F000323 SS=D	<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 observation, interview, and record review, the facility failed to ensure effective safety interventions and/or supervision were provided, in that, supervision was not provided and a call light was not within easy reach for a resident identified as being at a high risk for experiencing a fall and the resident experienced 2 falls for 1 of 3 residents who met the criteria for review of fall. (Resident #95)</p> <p>Findings include:</p> <p>During an interview on 07/16/14 at 2:28 P.M. UM (Unit Manager) #5 indicated Resident #95 experienced a fall on 07/14/14 with no injury.</p> <p>On 07/17/14 at 10:15 A.M., Resident #95</p>	F000323	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on August 12, 2014.</p> <p>F323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The resident affected by the alleged deficient of practice resident #95 care plan has been updated and</p>	08/12/2014

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	<p>was observed lying in bed. The call light was observed, at that time, to be clipped to the upper half of the mattress behind the head of Resident #95. During an interview, at that time, Resident #95 indicated she could not reach the call light.</p> <p>The clinical record of Resident #95 was reviewed on 07/17/14 at 3:00 P.M. The record indicated the diagnoses of Resident #95 included, but were not limited to, hx (history of) falls, osteoporosis, compression fracture of spine, and kyphotic deformity (a curvature of the spine).</p> <p>The most recent MDS (Minimum Data Set Assessment) dated 06/11/14 indicated Resident #95 experienced minimal cognitive impairment, no signs or symptoms of delirium, and unsteady balance during transitions. The MDS further indicated Resident #95 required the extensive assistance of 2 staff for transfers, extensive assist of two staff for toileting, and was only able to stabilize balance with human assistance.</p> <p>A Care Plan for Falls dated, 02/28/14 for identified a problem of, "Falls...at risk for fall due to:...weakness, confusion, unsteady gait at times, expresses fear of falling, Hx of fall, use of mobility</p>		<p>reflecting residents fall risk and current ADLs. Resident #95 call light is in place and at easy reach for resident.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. DNS/Nurse managers /Designee performed a fall risk assessment on every current resident and new admissions and address any concerns per protocol. ·MDS coordinator/designee has reviewed all residents care plans to ensure monitoring was provided per plan of care regarding at risk for fall and will assess each new resident and create care plan for at risk for fall. ·DNS/Licensed Nurse/Designee will perform a daily audit of falls and ensure proper interventions are in place and to ensure call light is within reach. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Education on fall hazards and proper interventions has been provided to nursing staff by DNS/DNSS/Designee by August 11, 2014 ·Documentation review will be 				

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	<p>devices, kyphosis, osteoporosis, ...poor safety awareness..." indicated the intervention was "call light in reach".</p> <p>An OT (Occupational Therapy) Discharge note 06/17/14 indicated, "...Precautions: Balance precautions include fall risk..."</p> <p>A Resident Profile provided by the ADON (Assistant Director of Nursing) 07/21/14 at 10:27 A.M., indicated Resident #95 required the assistance of 1-2 staff for transfers.</p> <p>A Resident Progress Note dated 07/14/14 3:15 P.M. indicated, "Resident was assisted to shower room for a shower by the Hospice CNA. CNA stated, 'She used the toilet (sic) ...When getting up from the toilet (sic) had one hand on the walker and one hand on the grab bar by toilet (sic). Resident went to adjust housecoat and slid to the floor. CNA tried to catch her but was unable to get there fast enough.' ...CNA educated ... stand within reach with transfers and ambulation..."</p> <p>A Care Plan for Falls dated 07/14/14 indicated Resident #95 experienced a fall on that date and included an immediate intervention of, "Hospice CNA Education about using a gait belt and staying close</p>		<p>conducted by DNS/Designee daily and be performed by DNS/nurse managers/designee to ensure monitoring of residents with fall risk according to care plan and any issues will be immediately reported to ED/DNS/Nurse manager /Designee for appropriate follow up.</p> <p>·DNS/Designee will conduct rounds on each shift to ensure fall interventions are in place per care plan and call light is within reach to the resident.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·DNS/Nurse managers/Designee will round daily using fall management CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place according to care plans.</p> <p>·If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p> <p>Compliance date: August 11, 2014</p>		

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	<p>to the resident with transfers and ambulation."</p> <p>An IDT (Interdisciplinary Team) Progress Note dated 07/15/14 at 10:09 A.M. indicated, "IDT review of witnessed fall that occurred on 07/14/14 at 3:00 P.M. Res (Resident) was using the toilet in the shower room prior to fall. Res was being assisted to shower per hospice CNA...No injuries noted. Hospice CNA stated that Res got up from toilet and had one hand on walker and one hand on metal grab bar by toilet. Res attempted to fix house coat and slid down to the floor. Hospice CNA said she tried to catch her but could not get to her fast enough...Immediate intervention Hospice CNA was educated ...staying close to Res with ambulation and transfers...".</p> <p>During an interview on 07/21/14 at 10:30 A.M., Resident #95 was observed sitting in her room in a wheelchair. During an interview, at that time, Resident #95 indicated she had experienced a fall over the weekend because she was trying to reach for the call light. Resident #95 further stated, at that time, "...The call light was way up there by the top of the bed behind my pillow, just like it is now. I reached for it and slid right out of the wheelchair..." The call light was observed, at that time, to be clipped the</p>			

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	<p>top 1/3 of the mattress behind the pillow and to not be within the easy reach of Resident #95.</p> <p>A Resident Progress note dated 07/17/14 at 6:45 P.M. indicated, "Resident was assisted back from the dining room...Call light was placed within reach. Call light sounded and staff went into bedroom found resident lying on the floor by her w/c (wheelchair)...Resident stated she was trying to go to bed or grab call light and slid to floor...no injuries noted...call light attached to bed and in residents (sic) hand...educated resident on no self transfers r/t (related to) weakness, use of call light for assistance before attempting to transfer..."</p> <p>An IDT Progress note dated 07/18/14 1:01 P.M. indicated, "...IDT review of un-witnessed fall that occurred on 07/17/14 at 6:10 P.M. Res was assisted back from dining room to bedroom in w/c. Call light was placed in reach. Call light sounded and staff entered the room and found Res on floor next to W/C ...Res stated she was trying to get in bed or grab call light and slid to floor... No injuries noted...Immediate intervention Res was assisted to bed. Call light attached to bed and placed in hand. Bed and chair alarms placed..."</p>						

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F000465 SS=E	<p>During an interview on 07/21/14 at 1:00 P.M., the Rehab Manager indicated Resident #95 was not able to maintain balance while standing without staff assistance.</p> <p>During an interview on 07/23/14 at 3:00 P.M. the DON indicated Resident #95 had been identified as being at a high risk to experience a fall, should have been provided two staff for transfers, should have had the call light placed within easy reach, and/or been provided supervision to ensure safety.</p> <p>3.1-45(a)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure housekeeping services were provided to maintain the facility in a sanitary condition and in good repair, in that, 5 of 17 resident bathrooms located on the 300 and 400 units had a pervasive urine odor and/or were soiled and in disrepair on 3</p>	F000465	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible</p>	08/12/2014

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	<p>of 5 survey days.</p> <p>(Room 306, Room 314, Room 401, Room 406, Room 415)</p> <p>Findings include:</p> <p>1. On 7/22/14 at 11:10 A.M., documentation entitled "Resident Council Meeting Follow Up" dated 6/19/14 was reviewed. The documentation indicated, "...The following area of concern was voiced at the Resident Council Meeting on 6-18-14. *Please respond to this concern within seven days of the Resident Council Meeting. Concern: Floors in Bathrooms/Rooms are not very clean..." "...Action Taken: Floors in bathroom/room were addressed. Cleaned rooms of concern. The rooms are on a cleaning schedule but also with room remodel soon it will help due to age of current rooms..."</p> <p>2. On 7/16/14 at 10:43 A.M. and 7/17/14 at 9:13 A.M., the bathroom floor of room 306 had brown soiling through out the floor and around the edges of the floor and on the caulking at the base of the commode.</p> <p>3. On 7/16/14 at 11:59 A.M., and 7/22/14 at 10:30 A.M., the bathroom floor of</p>		<p>Allegation and requests a Post Certification Desk Review in lieu of a Post Survey Revisit on August 12, 2014.</p> <p>F465 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>· The resident's rooms affected by the alleged deficient practice have been identified by housekeeping and housekeeping staff has been given a new cleaning schedule for rooms and bathrooms. Rooms 306, 314, 401, 406, 415 have been thoroughly cleaned and repaired.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>· All residents have the potential to be affected by the alleged deficient practice. Housekeeping supervisor/ED/DNS/Nurse managers /Designee performed aroom/bathroom audit on every current resident room, all necessary cleaning and repairs completed. · Housekeeping supervisor/ED/Designee will perform a daily audit of all bathrooms to ensure cleanliness.</p> <p>What measures will be put into</p>				

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	<p>room 314 had brown soiling through out the floor and on the caulking at the base of the commode and behind the toilet and the floor edges.</p> <p>4. On 7/16/14 at 2:51 P.M. and 7/22/14 at 9:58 A.M., the bathroom floor of room 401 had black soiling especially around the edges of the floor and on the caulking at the base of the commode.</p> <p>5. On 7/21/14 at 10:40 A.M., room 406's bathroom had a strong urine odor. The bathroom floor had soiling through out and was soiled at the floor edges. The caulking at the base of the commode was missing and/or had black soiling. The front edge of the bowl of the commode had 2 dried areas of bowel movement (bm) approximately the size of a nickel with pin point dried bm specks noted on the wall and baseboard next to the commode.</p> <p>On 7/22/14 at 9:55 A.M., the bathroom of room 406 had a pervasive urine odor. The dried bm areas on the commode bowl and the bm specks on the wall and baseboard were still present. The flooring at the base of the commode and the caulking around the commode were soiled. A towel had been rolled up and placed around the base of the commode. The bathroom floor was soiled and sticky</p>		<p>place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Education on bathroom cleanliness has been provided to all staff by CEC/Housekeeping supervisor/Designee by August 11, 2014. ·The housekeeping supervisor/designee will conduct daily audits of bathrooms to ensure cleanliness of bathroom. ·Staff will utilize deep cleaning schedule/daily cleaning schedule to ensure resident's rooms are monitored and cleaned daily. ·Housekeeping supervisor/Customer care representative/ED/DNS /designee daily will conduct rounds to ensure resident's rooms/bathrooms are monitored. ·In addition to cleaning and repairs remodeling of 300-400 hall bedrooms and bathrooms for removal of floor, wallpaper, and new paint and new flooring to be installed. 300-400 resident rooms have been currently under construction since 7/7/14. ED/designee to ensure construction to maintain on schedule for completion. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Housekeeping supervisor/Designee will round daily 				

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	<p>when walked on.</p> <p>On 7/22/14 at 10:30 A.M., the Administrator was made aware of Room 406's bathroom floor being soiled, bm areas on the commode and wall, and the pervasive urine odor. She agreed the bathroom floor was soiled and the urine odor was present and pervasive.</p> <p>6. On 7/22/14 at 10:00 A.M., the bathroom of room 415 had a strong urine odor. The bathroom floor had soiling through out. The wall covering around the soap dispenser was peeling off the wall. A metal bar on the wall by the commode had a metal ring loose on one side of the bar.</p> <p>7. On 7/22/14 at 10:35 A.M., the Administrator was made aware of the bathroom floor being soiled and the urine odor of the bathroom of room 415 and bathroom of room 314. The Administrator indicated at that time the bathroom floors were soiled and a urine odor was present.</p> <p>8. On 7/23/14 at 8:00 A.M., during interview with the Administrator she indicated she felt like urine had penetrated into the dated bathroom floors contributing to the urine odors in the bathrooms.</p>		<p>using resident room cleaning CQI tool x 2weeks then weekly x 12 weeks then monthly x 6 months to ensure preventative measures are in place.</p> <p>-If a threshold of 95% is not achieved an action plan will be developed. Findings will be reported in continuous quality improvement every month for a minimum of 6 months.</p> <p>Compliance date: August 11, 2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 7/23/14 at 9:00 A.M., the Housekeeping Supervisor provided the deep cleaning schedule for the 300 and 400 units. She indicated at that time that resident rooms and resident bathrooms were cleaned daily.</p> <p>3.1-19(f)</p>				