

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155679	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER BETHLEHEM WOODS NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4430 ELSDALE DR FORT WAYNE, IN 46835
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(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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00175111 and IN00176070.</p> <p>Complaint IN00175111 Substantiated. Findings related to the allegations are cited at F157, F241, F309, and F315</p> <p>Complaint IN00176070 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: June 22, 23, 24, and 25, 2015</p> <p>Facility number : 000260 Provider number: 155679 AIM number: 100267820</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census payor type: Medicare: 8 Medicaid: 57 Other: 17 Total: 82</p> <p>Sample: 7</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 any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Based upon past survey history and no harm identified to any resident; this facility respectfully requests a desk review in lieu of a post survey revisit on or before 7/17/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>			

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	<p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify the family of a medication change for 1 of 3 residents reviewed for family notification in sample of 7 (Resident #G)</p> <p>Findings include:</p> <p>Resident #G's record was reviewed 6-25-2015 at 10:18 AM. Resident #G's diagnoses included but were not limited to high blood pressure, depression, and dementia.</p> <p>A physician's order dated 5-21-2015 indicated to give Aricept (a medication for dementia) 5 milligrams (mg) daily. The order included a notation the order was taken on 5-21-2015 at 12:57 PM. Additionally, the order indicated the family was notified of the new order on 5-21-2015 at 12:57 PM.</p> <p>A physician's order dated 6-20-2015 indicated to increase the dose of Aricept from 5 mg to 10 mg daily. The order included a notation the family was notified of the new order on 5-21-2015 at 12:57 PM. The same notation from the previous Aricept order.</p>	F 0157	F0157 It is the practice of this provider that families will be notified of all medication changes. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #G's POA had been in facility on 6/20/15. She was notified of medication change at that time. Resident #G POA requested medication be discontinued on same date. NP notified, with new order to discontinue medication. POA notified of new order to discontinue medication on same date. Current medication list reviewed with POA on 6/20/15, with no other medication changes requested. All resident orders for last 30 days reviewed by DNS with family notification documented appropriately. How other residents having the potential to affected by the same deficient practice will be identified and what corrective actions will be taken: DNS/designee will review all resident medication changes for last 30 days and ensure documentation of family notification is present. If any medication change has occurred without appropriate family notification and/or documentation of notification, DNS/designee will notify	07/10/2015			

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	<p>In an interview on 6-22-2015 at 11:35 AM, Resident #G's family member indicated the facility had not notified them of the medication order or the increase in dosage.</p> <p>A review of Nurse's progress notes did indicate the family had been notified of the original order but not of the increase in the medication dosage.</p> <p>In an interview on 6-25-2015 at 11:08 AM, RN #1 indicated the family should have been notified of new physician orders and of medication changes.</p> <p>This Federal tag is related to Complaint IN 00175111.</p> <p>3.1-5(b)(1)</p>		<p>family immediately. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All nurses on all shifts Monday-Sunday will be re-educated by Clinical Education Coordinator/Weekend Supervisor on prompt family notification of medication changes. Orders will be reviewed by DNS/Designee on following business day to ensure family notification has occurred timely. How the corrective actions will be monitored to ensure that the deficient practice will not recur, ie what quality assurance program will be put into place; and by what date the systemic changes will be completed: To ensure compliance, the DNS/Designee is responsible for the completion of the Family Interview CQI (which specifically addresses notification of changes in condition) weekly times 4 weeks, monthly times 6 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Orders will be checked daily by DNS/designee to ensure compliance with family notification and appropriate documentation of notifications. Non-compliance</p>				

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F 0241 SS=D Bldg. 00	<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, record review, and interview, the facility failed to ensure clothing was changed daily for 2 of 3 residents reviewed for clothing changes in a sample of 7. (Resident #E and Resident #G)</p> <p>Findings include:</p> <p>1. Resident #E's record was reviewed 6-24-2015 at 2:26 PM. Resident #E's diagnoses included but were not limited to dementia, anorexia, and diverticulitis.</p> <p>During an observation on 6-22-2015 at 9:10 AM, Resident #E was up in the wheelchair, dressed on a beige blouse with blue circles, and green colored slacks.</p> <p>During an observation on 6-23-2015 at 1:12 PM, Resident #E was observed in a</p>	F 0241	<p>with facility policy/procedure will result in re-education and possible disciplinary action. Date systemic change will be completed: 7/10/15</p> <p>F0241 It is the practice of this provider to ensure that all residents' clothing is changed daily, in accordance with their plan of care. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #E and Resident #G were immediately assisted with appropriate clothing change upon staff notification of clothing not being changed for period lasting longer than one day. On 6/24/15, all residents assessed by DNS/ADNS/CEC/MDSC to ensure that clothing currently being worn was clean and in good repair. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: On 6/24/15, all residents were assessed by DNS/ADNS/CEC/MDSC to ensure that clothing being worn</p>	07/10/2015

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	<p>wheel chair. Resident #E had the same beige blouse on with blue circles, and green colored slacks on.</p> <p>A review of Resident #E's care plan did not indicate Resident #E resisted having clothing changed.</p> <p>2. Resident #G's record was reviewed 6-25-2015 at 10:18 AM. Resident #G's diagnoses included but were not limited to high blood pressure, depression, and dementia.</p> <p>During an observation on 6-22-2015 at 11:33 AM, Resident #G was observed to have on a gray colored T-shirt with a yellow sports logo and khaki multi pocket shorts.</p> <p>During an observation on 6-23-2015 at 8:45 AM, Resident #G was observed to have on the same gray colored T-shirt with a yellow sports logo and khaki multi pocket shorts.</p> <p>During an observation on 6-24-2015 at 9:48 AM, Resident #G was observed to have on the same gray colored T-shirt with a yellow sports logo and khaki multi pocket shorts.</p> <p>A review of Resident #G's care plans did not indicate Resident #G refused to have</p>		<p>was clean and in good repair. No other residents noted with issues. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All departments heads/weekend supervisor will conduct daily rounds to ensure that residents are wearing clean clothing and that clothing is being changed on a daily basis. Daily rounds will be recorded and submitted to ED for review daily. Nursing staff on all shifts Monday-Sunday will be re-educated by CEC/weekend supervisor on changing residents' clothing daily and reporting non-compliance with changing clothing to SSD. SSD will update plan of care as indicated. How the corrective actions will be monitored to ensure that the deficient practice will not recur, ie what quality assurance program will be put into place; and by what date the systemic changes will be completed: To ensure compliance, the DNS/Designee is responsible for the completion of the Resident Care Rounds CQI (which specifically addresses changing clothing) weekly times 4 weeks, monthly times 6 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of</p>	

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F 0309 SS=D Bldg. 00	<p>clothing changed.</p> <p>In an interview on 6-24-2015 at 3:05 PM, RN #2 indicated the staff were to be sure clothing was different daily, however, if the same staff were not on duty, they may not have know the outfit the resident had worn the day prior.</p> <p>A review of staffing for Resident #G on 6-22, 6-23, and 6-24-2015 indicated CNA #3 worked all three days, and CNA #4 worked on 6-22, and 6-24.</p> <p>In an interview on 6-24-2015 at 3:00 PM, CNA #3 indicated laundry brings clothing back quickly through the day, but usually not quickly enough to get the same outfit on a person 2 days in a row. Further, CNA #3 indicated resident clothing should be changed daily.</p> <p>This Federal tag is related to Complaint IN00175111</p> <p>3.1-3(t)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility</p>		95% is not achieved, an action plan will be developed to ensure compliance. ED will ensure that documentation of room rounds are completed daily by department head staff. Nursing staff found to be in non-compliance with facility policy/procedure will be subject to re-education and possible disciplinary action. Date systemic change will be completed: 7/10/2015		

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	<p>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, record review, and interview, the facility failed to ensure toenails were kept at a comfortable length for 1 of three residents reviewed for toenail hygiene in a sample of 7. (Resident #G)</p> <p>Findings include:</p> <p>Resident #G's record was reviewed 6-25-2015 at 10:18 AM. Resident #G's diagnoses included but were not limited to high blood pressure, depression, and dementia.</p> <p>During an observation on 6-22-2015 at 11:33 AM, Resident #G's toenails were observed to be long and curled over the end of the toes. Further, Resident #G's family member was clipping the toenails.</p> <p>A review of Resident #G's Care plans did not indicate when Resident #G was to receive toenail care.</p> <p>In an interview on 6-22-2015 at 11:35 AM, Resident #G's family member indicated the facility had been asked to</p>	F 0309	<p>F0309 It is the practice of this provider to ensure that all toenails are kept at a comfortable length. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #G's toenails were trimmed on 6/22/15. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents were assessed for need for toenail trimming by CEC/MDSC/DNS/ADNS/Medical Records. All toenails were trimmed that exhibited need. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Nursing staff will be re-educated on ensuring that toenails are trimmed when receiving showers and as needed. Residents whose toenails are unable to be trimmed by staff will be referred to podiatrist for care. Residents who are resistant to toenail care will be referred to podiatry/ social services, and plan of care will be updated as appropriate. How the corrective actions will be</p>	07/10/2015

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F 0315 SS=D Bldg. 00	<p>keep Resident #G's toenails clipped.</p> <p>In an interview on 6-23-2015 at 8:53 AM, RN #5 indicated residents were to have their nails clipped by the Podiatrist, or with showers as needed.</p> <p>This federal tag is related to Complaint IN00175111</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>monitored to ensure that the deficient practice will not recur, ie what quality assurance program will be put into place; and by what date the systemic changes will be completed: Podiatrist progress notes will be reviewed by SSD to ensure that all residents who have been referred to podiatrist were seen. MDSC/SSD will initiate appropriate care plans for residents who are resistant to personal. Any member of nursing staff found to be non-compliant with facility policy/procedure will be subject to re-education and possible disciplinary action. ADNS/Designee will review residents' shower reports weekly to ensure nail care is being provided appropriately. Whole house skin sweeps will be conducted quarterly by ADNS/Designee.</p> <p>Date systemic changes will be completed: 7/10/15</p>	

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	<p>Based on observation, interview, and record review, the facility failed to ensure incontinence care as outlined in the care plan for 2 of 3 residents reviewed for incontinence care in a sample of 7. (Resident #E and Resident #G)</p> <p>Findings include:</p> <p>1. Resident #E's record was reviewed 6-24-2015 at 2:26 PM. Resident #E's diagnoses included but were not limited to dementia, anorexia, and diverticulitis.</p> <p>During observations on 6-24-2015 between 9:49 AM and 12:12 PM, Resident #E was observed in bed, resting. At 12:12 PM, CNA #3 and CNA #6 entered the room and assisted Resident #E up into the wheelchair for lunch. Resident #E was observed to have a wet area on the front of the slacks about 4 inches by 2 inches close to the right thigh. Resident #E was taken to the dining room without being toileted.</p> <p>A review of Resident #E's care plan titled incontinence indicated Resident #E was to be checked for incontinence and changed every 2 hours.</p> <p>2. Resident #G's record was reviewed 6-25-2015 at 10:18 AM. Resident #G's</p>	F 0315	<p>F0315 It is the practice of this provider to ensure incontinence care is provided in accordance with the plan of care for our residents. What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident #E and Resident #G were provided with incontinent care. Resident #E and Resident #G's care plans were reviewed by IDT team to ensure current plan of care for incontinence was appropriate, which team determined to be accurate. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents assessed by DNS/ADNS/MDSC/CEC/Medical Records to ensure that they were clean, dry, and odor-free. No other residents noted to be currently incontinent at time of assessments. All toileting programs reviewed by IDT team to ensure that current plan of care is appropriate for all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All nursing staff will be re-educated by CEC on following plan of care for toileting/incontinence for all residents. Staff will be educated to notify MDSC for changes in continence. MDSC</p>	07/10/2015

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	<p>diagnoses included but were not limited to high blood pressure, depression, and dementia.</p> <p>During an observation on 6-24-2015 at 11:48 AM, Resident #G was observed with a large, wet area on the front of his shorts approximately the size of a baseball.</p> <p>During an observation on 6-24-2015 at 1:00 PM, Resident #G was observed with a large, wet area on the front of his shorts approximately the size of a baseball.</p> <p>A review of Resident #G's care plan titled toileting program indicated Resident #G should have been toileted before and after meals.</p> <p>In an interview on 6-24-2015 at 11:08 AM, RN #1 indicated residents should be toileted according to their care plans.</p> <p>This Federal tag is related to Complaint IN00175111</p> <p>3.1-41(a)(2)</p>		<p>will initiate 3-day bowel and bladder assessment for all residents with change in continence to ensure that plan of care is appropriate and individualized to residents' needs. How the corrective actions will be monitored to ensure that the deficient practice will not recur, ie what quality assurance program will be put into place; and by what date the systemic changes will be completed: To ensure compliance, the MDSC/Designee is responsible for the completion of the Bladder Program CQI weekly times 4 weeks, monthly times 6 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance.</p> <p>Toileting/incontinence plan of care will be reviewed quarterly and as needed for changes in condition by MDSC. Any staff member found to be non-compliant with following plan of care will be subject to re-education and possible disciplinary action. Date systemic changes will be completed: 7/10/15</p>		