

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/27/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00180480.</p> <p>Survey dates: August 20, 21, 24, 25, 26, and 27, 2015</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Census bed type: SNF/NF: 142 Total: 142</p> <p>Census payor type: Medicare: 18 Medicaid: 100 Other: 24 Total: 142</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The Facility requests a desk review</i></p>	
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED			

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>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to develop accurate MDS (Minimum Data Set) assessments related to urinary incontinence for 2 of 3 residents reviewed for urinary incontinence in a total sample of 43 residents reviewed. (Resident #D & #B)</p> <p>Findings include:</p> <p>1. The quarterly MDS (Minimum Data</p>	F 0278	F 278 ASSESSMENT ACCURACY/ COORDINATION/CERTIFIED I. Resident # B no longer resides in the facility. Resident # B's assessments were modified to reflect accurate urinary incontinence status. Resident #D's MDS assessments were reviewed for accuracy and modified to reflect accurate urinary incontinence status. II. All residents residing in the	09/23/2015

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	<p>Set) assessment, dated 07/24/2015, indicated Resident #D was severely cognitively impaired. The assessment indicated the resident was occasionally incontinent of bladder and bowel.</p> <p>The CNA (Certified Nursing Aide) monthly "Flow Sheet Record", dated 07/01/2015 through 07/31/2015, indicated Resident #D was incontinent every day on the 6:00 A.M. to 2:00 P.M. shift, 2:00 P.M. to 10:00 P.M. shift and the 10:00 P.M. to 6:00 A.M. shift.</p> <p>The clinical record for Resident #D was reviewed on 08/26/2015 at 10:42 A.M. Diagnoses included, but were not limited to, dementia, manic depression, psychotic disorder, schizophrenia, chronic obstructive pulmonary disease, hypertension, and cerebrovascular accident.</p> <p>During an interview on 08/26/2015 at 9:12 A.M., CNA #14 indicated Resident #D was always incontinent of bladder and bowel.</p> <p>During an interview on 08/26/2015 at 11:33 A.M., CNA #6 indicated Resident #D can sometimes ask to use the restroom, but she was incontinent of bowel and bladder.</p>		<p>facility have the potential to be affected. III. MDS Nurse received education regarding coding all MDS sections correctly. MDS Nurse received education regarding how to correct documentation found to be incorrect during the assessments and interviews performed by MDS. New CNA ADL sheets will be provided to ensure clear and accurate documentation and nursing staff will be educated regarding completion. Education regarding documentation will include how to document incontinent episodes and continent episodes. Education also includes when documentation is to be completed. Newly hired staff will receive same education during orientation. IV. The Director of Nursing Services or designee will randomly audit for MDS accuracy, 5 MDS assessments per week indefinitely. Any MDS that has incorrect information will be modified to reflect accurate documentation immediately. The results of the audits will be presented to the monthly Performance Improvement meeting to determine when the frequency of the audits may be reduced however, an audit will continue indefinitely. Date of completion: 9/23/2015</p>				

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	<p>During an interview, the MDS coordinator indicated the CNA's did not understand how to document correctly for urinary incontinence and "most of the CNA documentation was marked incontinent for Resident #D which was wrong".</p> <p>During an interview on 08/27/2015 at 11:02 A.M., the MDS coordinator indicated she spoke with the CNAs on duty in Harmony Way and had the CNA on duty place a C (Continent) on the CNA monthly "Flow Sheet Record", dated 08/27/2015 for the shift of 6:00 A.M. to 2:00 P.M., implying Resident #D was continent of bladder. This was documented at 11:02 A.M. when the shift was not completed till 2:00 P.M.</p> <p>During an interview on 08/27/2015 at 11:10 A.M., the DCO (District Director of Clinical Operations) when asked about the CNA documentation for 08/27/2015, the shift from 6:00 A.M. to 2:00 P.M., the DCO indicated it was incorrect and she would "handle it".</p> <p>2. The quarterly MDS assessment, dated 06/26/2015, indicated Resident #B was alert and oriented. The functional status for Resident #B was extensive assistance required with one person. The bladder and bowel function for Resident #B was</p>			

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F 0279 SS=D Bldg. 00	<p>listed as occasionally incontinent of bladder and bowel.</p> <p>The CNA monthly "Flow Sheet Record" indicated Resident #B was incontinent on all days of June, 2015.</p> <p>The closed clinical record for Resident #B was reviewed on 08/27/2015 at 9:37 A.M. Diagnoses included, but were not limited to, diabetes mellitus, cerebrovascular accident, hypertension, hypernatremia, hyperosmolality, and atrial fibrillation.</p> <p>During an interview on 08/27/2015 at 11:10 A.M., the DCO (District Director of Clinical Operations) indicated the MDS coordinator used the CNA monthly "Flow Sheet Record" when assessing the incontinence or continence of a resident.</p> <p>3.1-31(d)</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 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</p>			

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	<p>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 interview and record review, the facility failed to develop care plans related to urinary incontinence for 1 of 3 residents reviewed for urinary incontinence, in a total sample of 13 residents reviewed for care plans. (Resident #E)</p> <p>Findings include:</p> <p>An interview was conducted on 08/26/2015 at 1:47 P.M. with LPN (Licensed Practical Nurse) #4. LPN #4 indicated Resident #E was usually incontinent but at times was aware of the need to use the bathroom. LPN #4 further indicated Resident #E came to the unit 4 months ago, was sent out to the hospital for frequent falls and a decline in condition. Resident was diagnosed with Clostridium Difficile and a Urinary Tract Infection while in the hospital. Resident returned to the facility on Hospice care with an increase in incontinence,</p>	F 0279	<p>F 279 DEVELOP COMPREHENSIVE CARE PLANS</p> <p>1. Resident # E's documentation, MDS's and care plans were reviewed and added care plan for management of resident's incontinence.</p> <p>2. All residents residing in the facility have the potential to be affected.</p> <p>1. MDS Nurse and Nursing Managers were provided education regarding care plans. MDS Nurse is to ensure that care plans are in place for triggered Care Assessment Areas (CAA's) when initial assessment is completed, during Annual assessments, Significant Change Assessments and during each care plan review. Care plans will be updated during Interdisciplinary Meetings by Nursing Managers as needed.</p> <p>2. The Director of Nursing Services or designee will randomly audit for accuracy in all areas 5 complete MDS Admission, Annual or Significant</p>	09/23/2015

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F 0282 SS=E Bldg. 00	<p>confusion and a decline in overall health. Resident was wheelchair bound with incontinence checks upon rising, before and after meals and before bed.</p> <p>The significant change MDS (Minimum Data Set) assessment, dated 07/27/2015, was reviewed on 08/27/2015 at 8:42 A.M. The MDS indicated Resident #E was occasionally incontinent of urine. The care plan, updated on 08/18/2015, was reviewed. Resident #E had a care plan for falls related to incontinence, a care plan for impaired skin integrity related to incontinence, but no care plan for managing incontinence. Resident #E also had a stage 1 pressure ulcer on her coccyx measuring 1.6cm X 1.3cm.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure the plan of care was followed as written or physician orders were followed related to behavior/interventions of psychotropic</p>	F 0282	<p>Change in Condition Assessments and resident care plans weekly indefinitely. Any MDS that has incorrect information will be modified to reflect accurate documentation immediately. Residents with missing or incorrect care plans will be corrected. The results of the audits will be presented to the monthly Performance Improvement meeting to determine when the frequency of the audits may be reduced however, an audit will continue indefinitely. Date of completion: 9/23/2015</p> <p>F 282 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 1. Resident # B no longer resides in the facility. Resident # D and Resident #F were assessed and found to have no issues related to the alleged deficient</p>	09/23/2015	

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	<p>agents, administration and monitoring of medications for hypertension and oxygen, and urinary incontinence for 3 of 5 residents reviewed for care plans. (Resident #F, #B, & #D)</p> <p>Findings include:</p> <p>1. During an observation on 08/24/2015 at 9:26 A.M., Resident #F was sitting in a wheelchair in the 300 hallway by the shower room door. The resident's head was hanging down to his chest. Resident #F would lift his head and make comments to other resident's walking past, then CNA #24 walked up to Resident #F and moved the resident out of the hallway and into his room.</p> <p>The clinical record for Resident #F was reviewed on 08/24/2015 at 9:39 A.M. The diagnoses included, but were not limited to, dementia, hypertension, malaise, and anemia.</p> <p>Resident #F's Behavior Care Plan, which was initiated on 04/23/2015, indicated a potential to demonstrate physical behaviors of refusing care and hitting at staff. The interventions included, but were not limited to, "Administer and monitor the effectiveness of medications per physician order."</p>		<p>practice. Resident # D will be assessed for necessity of oxygen. Resident # D's care plan was updated to reflect that resident is non-compliant with oxygen and removes oxygen at times. Resident #F was assessed and found that a GDR or discontinuation of any of his psychoactive medication would be contraindicated and the risks outweighed the benefits of discontinuing his medication due to alleged inappropriate documentation.</p> <p>2.All residents residing in the facility have the potential to be affected.</p> <p>3.Nursing staff were provided education regarding behavior management, documentation of behaviors present, oxygen treatments,importance of and signing off medication and treatments as ordered. Documentation on behavior flow sheets will be changed to reflect documentation by exception. To document by exception on the flow sheets will mean that if the behavior was not present, it will be left blank. Any documentation on behavior flow sheets by the licensed nurse will be noted in the progress notes. Review of behavior documentation in nursing notes is a practice already in place during morning meeting. Side effect monitoring is already in place and charted by exception. During monthly behavior meetings, behavior</p>				

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	<p>Resident #F's Inappropriate Behaviors Care Plan, which was initiated 05/06/2015, indicated a potential to demonstrate sexually inappropriate behaviors. The interventions included, but were not limited to, "...monitor, redirect and return the resident to his room...."</p> <p>The "Behavior/Intervention Monthly Flow Records", dated May, June, July, and August, 2015, were reviewed on 08/24/2015 at 11:02 A.M. The following dates and times were left blank with no documentation of behavior monitoring for Resident #F: August 1, 2, 7, 8, 10, & 11, 2015 (A.M.) August 2 & 17, 2015 (P.M.) July 1, 4, 9,10, 16, 18, 20, 21, 24, 29, & 30, 2015 (A.M.) July 23, 2015 (P.M.) June 4, 6, 12, 16, 19, 22, 24, & 30, 2015 (A.M.) June 7, 16, & 18, 2015 (P.M.) May 12, 19, , 23, & 24, 2015 (A.M.) May 4, 7, &17, 2015 (P.M.)</p> <p>During an interview on 8/24/2015 at 10:08 A.M., CNA #24 indicated Resident #F had inappropriate behaviors and had to be watched around other residents.</p> <p>During an interview on 08/24/2015 at 1:33 P.M., LPN (Licensed Practical</p>		<p>monitoring sheets and behavior notes will be compared to ensure accurate documentation of behaviors. This information is shared with the Psychologist/Psychiatrist during the monthly behavior meetings.Nursing staff were provided education regarding documentation of services provided including medication, treatments, oxygen, toileting, bathing and grooming</p> <p>4.The Social Services Director and Director of Nursing Services or designee will randomly audit for accuracy behaviors present on behavior monitoring flow sheet daily 5 of 7 days per week for 60 days, then 3 days per week for 60 days. Any incorrect information will be modified to reflect accurate documentation immediately. The Director of Nursing Services or designee will audit MARs and TARs daily 5 of 7 days per week for complete and accurate documentation of services. Any missing or incorrect documentation will be corrected. The results of the audits will be presented to the monthly Performance Improvement meeting to determine when the frequency of the audits may be reduced however, an audit will continue indefinitely. Date of Completion: 9/23/2015</p>				

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	<p>Nurse) #19 indicated all behaviors and interventions were documented on the "Behavior/Intervention Monthly Flow Record". The current month flow chart was kept in the MAR (Medication Administration Record) and documented in the A.M. and P.M. every day for Resident #F. When a progress note pertains to the behavior a code was to be placed on the "Behavior/Intervention Monthly Flow Record".</p> <p>During an interview on 08/24/2015 at 1:41 P.M., the SSM (Social Service Manager) indicated the team met monthly to go over the resident's behaviors. During these meetings, the "Behavior/Intervention Monthly Flow Record' and physician's medication orders were reviewed. The SSM indicated Resident #F had episodes of inappropriate behaviors and was currently being monitored for those behaviors.</p> <p>During an interview on 08/27/2015 at 9:37 A.M., the DON (Director of Nursing) indicated the "Behavior/Intervention Monthly Flow Record" was where nursing staff were to document behavior/intervention signs and symptoms. The DON indicated the A.M. documentation designated box on the flow record was from 7:00 A.M. to</p>			

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	<p>7:00 P.M. and the P.M. documentation designated box on the flow record was from 7:00 P.M. to 7:00 A.M.</p> <p>2. A. During an interview on 08/18/2015 at 9:51 A.M., Resident #B's family member indicated the resident was left incontinent of urine.</p> <p>The closed clinical record for Resident #B was reviewed on 08/27/2015 at 09:37 A.M. Diagnoses included, but were not limited to, diabetes mellitus, cerebrovascular accident, hypertension, hypernatremia, hyperosmolality, and atrial fibrillation.</p> <p>Review of Resident #B's care plans, on 08/27/2015 at 10:00 A.M., indicated a care plan for hypertension related to a stroke dated 12/16/2014. The interventions included, but were not limited to, monitor/document abnormalities for urinary output.</p> <p>Review of the CNA (Certified Nursing Aide) monthly "Flow Sheet Record", dated 06/01/2015 to 06/30/2015, under Bladder indicated the staff was to document the number of times Resident #B was continent or incontinent.</p> <p>The CNA "Flow Sheet Record" for bladder assessment contained no</p>			

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	<p>documentation for the 6:00 A.M. to 2:00 P.M. shift for the following dates: June 12, 13, 14, 16, 17, 19, 20, 21, 23, 24, 26, 27, 28, 29, and 30, 2015.</p> <p>The CNA "Flow Sheet Record" for bladder assessment contained no documentation for the 2:00 P.M. to 10:00 P.M. shift for the following dates: June 5, 6, 8, 9, 10, 11, 15, 17, 18, 20, 21, 25, 26, 28, 29, and 30, 2015.</p> <p>The CNA "Flow Sheet Record" for bladder assessment contained no documentation for the 10:00 P.M. to 6:00 A.M. shift for the following dates: June 30, 2015.</p> <p>The quarterly MDS assessment, dated 06/26/2015, indicated Resident #B was alert and oriented. The functional status for Resident #B was extensive assistance required with one person. The bladder and bowel function for Resident #B was listed as occasionally incontinent of bladder and bowel.</p> <p>2. B. Resident #B's care plans were reviewed on 08/27/2015 at 10:00 A.M. The care plan for coronary artery disease, dated 12/16/2014, included interventions, but were not limited to: "Give all cardiac medications as ordered by the physician, monitor and document side effects, give</p>			

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	<p>medications for hypertension and document response to medications and any side effect, and monitor blood pressure and notify physician of any abnormal readings."</p> <p>Review of Resident #B's "Medication Administration Record", dated 06/01/2015 through 06/30/2015, indicated Resident #B did not receive his Lisinopril 20 milligrams by mouth daily on 06/17/2015 and 06/19/2015, and Resident #B did not receive his Amlodipine 5 milligrams by mouth daily on 06/17/2015 and 06/19/2015.</p> <p>Review of Resident #B's "Weights and Vitals Summary", dated 06/16/2015, indicated the resident's blood pressure was 177 systolic and 90 diastolic.</p> <p>Review of Resident #B's "Weights and Vitals Summary", dated 06/19/2015 indicated the resident's blood pressure was 199 systolic and 98 diastolic.</p> <p>Review of Resident #B's "Weights and Vitals Summary", dated 06/27/2015, indicated the resident's blood pressure was 217 systolic and 99 diastolic.</p> <p>Review of Resident #B's "Weights and Vitals Summary". dated 06/28/2015, indicated the resident's blood pressure</p>			

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	<p>was 211 systolic and 94 diastolic.</p> <p>Review of Resident #B's "Progress Notes", from 06/16/2015 through 06/30/2015, indicated no documentation pertaining to blood pressure trending upward or abnormal.</p> <p>Review of Resident #B's "Progress Notes", dated 07/02/2015 at 15:17 (3:17 P.M.), indicated the resident had increased mumbled speech and incontinence.</p> <p>Review of Resident #B's "Progress Notes", dated 07/02/2015 at 16:40 (4:40 P.M.), indicated the physician was notified of the resident's change in condition.</p> <p>3. The clinical record for Resident #D was reviewed on 08/26/2015 at 10:42 A.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, cerebrovascular accident, dementia, manic depression, psychotic disorder, schizophrenia, and hypertension.</p> <p>The physician's order, dated 04/14/2015, indicated Resident #D was to have oxygen therapy at 2 liters per minute by nasal cannula. The resident's condition for oxygen therapy was shortness of air.</p>			

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	<p>The care plan, dated 04/15/2015, indicated Resident #D had a diagnosis of COPD (Chronic Obstructive Pulmonary Disease). The interventions for COPD included, but were not limited to, "Administer medications as ordered, monitor for signs and symptoms and give oxygen as ordered."</p> <p>The MDS (Minimum Data Set) assessment was reviewed on 08/26/2015 9:26:25 AM. The quarterly MDS assessment, dated 07/24/2015, indicated Resident #D was severely cognitively impaired.</p> <p>During an observation on 08/26/2015 at 8:37 A.M., Resident #D was sitting in the small dining room located on Harmony Hall. The resident's nasal cannula was not in her nasal passages and was lying on the resident's right shoulder. CNA #14 walked up to Resident #D at 9:10 A.M., and placed the nasal cannula on Resident #D's face for proper oxygen administration.</p> <p>During an observation on 08/26/2015 at 11:00 A.M., Resident #D's nasal cannula was not in her nasal passageway. The ADON (Assistant Director of Nursing) walked up to Resident #D and asked the resident if she was ok, then walked back</p>			

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F 0312 SS=D Bldg. 00	<p>to the nurses desk without placing the resident's nasal cannula back in place. LPN #17 walked by Resident #D at 11:17 A.M., and placed Resident #D's nasal cannula back on the resident's face.</p> <p>During an observation on 08/26/2015 at 11:19 A.M., Resident #D's nasal cannula was not in the resident's nasal passages. CNA #6 walked up to Resident #D at 11:32 A.M., and placed Resident #D's nasal cannula back on the resident's face.</p> <p>The current "Comprehensive Care Plan" policy was provided on 08/26/2015 at 3:25 P.M. by the Executive Director. The policy was dated 01/07/2012. The policy indicated, "...Care plan in chart ...address the patient's needs..."</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on interview and record review, the facility failed to provide ADL (Activities of Daily Living) care to residents who were unable to perform</p>	F 0312	F 312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS I. Resident #B no longer resides in the facility. Residents # C and #G were assessed and no issues	09/23/2015

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	<p>ADL's for themselves for 3 of 7 residents reviewed for ADL's. (Resident #C, #B, & #G)</p> <p>Findings include:</p> <p>I. Review of the nursing assistant's "Flow Sheet Record" for ADL's, dated July, 2015 through August, 2015, indicated oral care was to be performed twice daily and as needed, once on first shift and once on second shift. Resident #C's "Flow Sheet Record" was left blank on the following dates: 08/05/2015 2nd shift, 08/01/2015 2nd shift, 07/31/2015 1st shift, 07/30/2015 1st shift, 07/27/2015 2nd shift, 07/23/2015 1st shift, 07/22/2015 2nd shift, 07/20/2015 2nd shift, 07/17/2015 2nd shift, 07/16/2015 1st shift, 07/15/2015 1st shift, 07/08/2015 2nd shift, 07/05/2015 1st shift, 07/02/2015 1st shift.</p> <p>Review of Resident #C's care plan for ADL's (activities of daily living), dated 08/02/2012, indicated Resident #C had self care performance deficits related to ADL's with a diagnosis of Alzheimer's Disease. The interventions for Resident #C included, but were not limited to, "Provide oral care and encourage the resident to assist with daily care."</p> <p>Review of the clinical record, on</p>		<p>found related to the alleged deficient practice. Resident #C care plans were updated to reflect current needs for ADL care. Resident #G has care plans in place regarding refusal of care including oral care. II. All residents residing in the facility have the potential to be affected. III. It is the policy of the facility that care is provided to residents to meet their highest potential. Nursing staff received education regarding documentation of ADL care provided. ADL care sheet was modified to ensure clear and accurate documentation of ADLs provided. CNA's are to report to nurse any refusals of ADL care. Families and outside care providers (such as hospice) of residents that have history of consistent refusals or are resistive to care will be notified of resident's refusals. Residents that consistently refuse ADL care that may affect their psychosocial well-being and health will have a care plan in place that reflects that behavior. Attempts will be made to determine reasons for refusal and interventions will be put into place to encourage residents to participate and allow ADL care. IV. The Director of Nursing Services or Designee will audit ADL records for missing or incomplete documentation daily for 5 of 7 days per week for 60 days, then 3 of 7 days per week for 90 days and weekly indefinitely. Any missing</p>		

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	<p>08/26/2015 at 09:13 A.M., indicated Resident #C's last dental exam was performed on 06/10/15. The exam indicated that Resident #C had fair oral hygiene.</p> <p>During an interview on 08/20/2015 at 2:20 P.M., Resident #C's family member indicated, Resident #C had bad breath on some occasions and was unsure if their family member had received oral care on a regular basis.</p> <p>During an interview on 08/26/2015 at 11:22 A.M., LPN (Licensed Practical Nurse) #16 indicated after all ADL's were performed they were to be documented on the "Flow Sheet Record". LPN #16 indicated Resident #C had not been able to self perform oral care without assistance since arriving to the facility.</p> <p>The MDS (Minimum Data Set) annual assessment, dated 06/02/2015 and reviewed on 08/26/2015 at 9:00 A.M., indicated Resident #C was severely cognitively impaired. The resident required extensive assistance of one for hygiene. The resident's diagnoses included, but were not limited to, hypertension, Alzheimer's Disease, and dementia.</p> <p>2. During an interview on 08/18/2015 at</p>		documentation will be immediately corrected to reflect care provided or refusal of care, whichever is accurate. There will be random visual audits of 5 dependent residents per week for cleanliness and grooming daily and any deficiencies corrected. The results of the audits will be presented to the performance improvement meeting monthly to determine when the audit frequency may be changed. Date of Completion: 9/23/2015				

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	<p>9:51 A.M., Resident #B's family member indicated the resident did not receive the number of baths necessary.</p> <p>During an interview on 08/26/2014 at 10:49 A.M., CNA # 25 indicated residents received a minimum of two showers/complete baths a week. The residents could have more than two baths a week when requested.</p> <p>Review of the nursing assistants "Flow Sheet Record", dated 06/01/2015 through 06/30/2015, indicated Resident #C should have received two complete baths/showers a week. Resident #C received a complete bath/shower on the following dates: 06/03/2015, 06/22/2015, 06/24/2015, and 06/27/2015.</p> <p>The CNA (Certified Nursing Aide) "Flow Sheet Record" for bathing indicated Resident #B received showers on 06/03/2015. Resident #B received a complete bath on 06/03/2015, 06/17/2015, 06/21/2015, 06/22/2015, and 06/24/2015 for the thirty days in the month of June.</p> <p>3. During an interview on 08/18/2015 at 9:51 A.M., Resident #B's family member indicated the resident was left incontinent of urine.</p>			

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	<p>During an interview on 08/26/2015 at 9:12 A.M., CNA #14 indicated the resident's ADL (Activity of Daily Living) care was documented on the nursing assistants "Flow Sheet Record".</p> <p>Review of the CNA "Flow Sheet Record" under "Bladder" indicated the staff was to document the number of times a resident was continent or incontinent.</p> <p>On the CNA "Flow Sheet Record" for bladder assessment, indicated there was no documentation listed for 15 days during June, 2015 for the 6:00 A.M. to 2:00 P.M. shift, no documentation listed for 16 days during June, 2015 for the 2:00 P.M. to 10:00 P.M. shift and no documentation listed for one day during June, 2015 for the 10:00 P.M. to 6:00 A.M. shift.</p> <p>The quarterly MDS assessment, dated 06/26/2015, indicated Resident #B was alert and oriented. The functional status for Resident #B was extensive assistance required with one person. The bladder and bowel function for Resident #B was listed as occasionally incontinent of bladder and bowel. Diagnoses included, but were not limited to, diabetes mellitus, cerebrovascular accident, and atrial fibrillation.</p>			

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	<p>4. During an interview with the family member of Resident #G, on 08/20/15 at 8:35 P.M., the family member indicated that on many times she had visited; the resident's teeth were unclean. She indicated at times the resident's teeth were brown with "gunk" on them. She indicated on one visit, she asked the staff to clean the resident's teeth while she was present. The staff looked in the resident's dresser drawers and was unable to locate a toothbrush or toothpaste. The family member indicated she has had to ask repeatedly for the resident's teeth to be cleaned.</p> <p>The clinical record for Resident #G was reviewed on 08/25/15 at 2:51 P.M. The diagnoses for Resident #G included, but were not limited to, dementia and Alzheimer's disease.</p> <p>The most recent annual MDS (minimum data set) assessment, dated 05/04/15, indicated Resident #G was severely cognitively impaired. The MDS also indicated Resident #G required extensive assistance with personal hygiene needing physical assistance of one staff person.</p> <p>During an interview at 10:45 A.M., on 08/26/15, the CNA (Certified Nursing Assistant) #1 indicated she provided care for Resident #G and the resident was</p>			

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	<p>supposed to receive oral care daily on each shift. The CNA indicated when oral care was provided, the CNA's documented the provided care on the resident's "Flow Sheet" . If a resident refused care, the nurse was notified and the nurse performed the care and documented it. CNA # 1 indicated Resident #G did not usually refuse care, he/she "takes some encouragement on some days" but would allow us to help.</p> <p>During an interview at 2:50 P.M., on 8/26/15, CNA #2 indicated she provided care for Resident #G on evening shift. CNA #2 indicated oral care was provided at bedtime and should be done daily.</p> <p>The Flow Sheet Record for August, 2015, for Resident #G, was provided by Unit Manager #7 on 08/26/15 at 8:40 A.M. and indicated the following:</p> <p>Nursing Order: Provide Oral Care - Twice Daily and PRN The following dates were blank, indicating care was not provided: August 3, 14 and 15, 2015 on first shift and August 3, 7, 9, 11, 14, 15, 18, 22, and 25, 2015 on second shift. There were no PRN (as needed) incidents of oral care being provided for the month of August, 2015.</p>			

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	<p>The Flow Sheet Record for July, 2015, for Resident #G, was provided by the Director of Nursing (DON) on 08/26/15 at 8:55 A.M. and indicated the following:</p> <p>Nursing Order: Provide Oral Care - Twice Daily and PRN The following dates were blank, indicating care was not provided: July 6, 7, 10, 14, 15, 19, 25, 26, 29, and 30, 2015 on first shift and July 1, 2, 3, 4, 5, 7, 10, 11, 12, 15, 26, 27, 28, 29, and 30, 2015 on 2nd shift. There were no PRN (as needed) incidents of oral care being provided for the month of July, 2015.</p> <p>The Flow Sheet Record for June, 2015, for Resident #G, was provided by Unit Manager #7 on 08/26/15 at 8:40 A.M. and indicated the following:</p> <p>Nursing Order: Provide Oral Care - Twice Daily and PRN The following dates were blank, indicating care was not provided: June 8, 12, 13, 14, 16, 17, 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30, 2015 on first shift and June 1, 2, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 22, 24, 25, 27, 28, 29, and 30, 2015 on second shift. There were no PRN (as needed) incidents of oral care being provided for the month of June, 2015.</p>			

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F 0328 SS=D Bldg. 00	<p>3.1-38(a)(3)(C) 3.1-38(b)(2)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to provide to provide proper treatment for special services of continuous oxygen therapy for 1 of 1 resident reviewed for oxygen services. (Resident #D)</p> <p>Findings include:</p> <p>During an observation on 08/26/2015 at 8:37 A.M., Resident #D was sitting in the small dining room located on Harmony Hall. The resident's nasal cannula was not in her nasal passages and was lying on the resident's right shoulder.</p> <p>During an observation on 08/26/2015 at 8:52 A.M., CNA (Certified Nursing Aide) #6, CNA #14 and LPN (Licensed</p>	F 0328	<p>F 328 TREATMENT/CARE FOR SPECIAL NEEDS I. Resident #D was assessed for need for oxygen. Resident # D continues to be monitored and if able will have her oxygen discontinued. Resident # D's MD was notified of her behavior of removing her oxygen. Resident # D's care plan was updated to reflect that resident removes her oxygen. II. All residents with oxygen have the potential to be affected. III. Nursing staff were educated regarding placing oxygen on residents when noted that it is not in their nares. If the resident refuses or removes oxygen the family and MD are to be notified and a care plan initiated. Residents that refuse oxygen will assessed for continued need and if able oxygen will be discontinued.</p>	09/23/2015	

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	<p>Practical Nurse) #15 walked past Resident #D without applying the oxygen to the resident.</p> <p>During an observation on 08/26/2015 at 9:09 A.M., LPN #16 walked past Resident #D. She did not apply the oxygen to the resident.</p> <p>During an observation on 08/26/2015 at 9:10 A.M., CNA #14 walked by Resident #D and picked up the resident's nasal cannula. CNA #14 then placed the nasal cannula on Resident #D's face for proper oxygen administration.</p> <p>During an observation on 08/26/2015 at 11:00 A.M., Resident #D's nasal cannula was not in her nasal passageway. The ADON (Assistant Director of Nursing) walked up to Resident #D and asked the resident if she was ok, then walked back to the nurses desk without placing the resident's nasal cannula back in place.</p> <p>During an observation on 08/26/2015 at 11:13 A.M., Resident #D's head was lying on the edge of the table. When the resident lifted her head, the nasal cannula was observed hanging off the resident's right ear and not in her nasal passageway. LPN #16 walked past the resident to the nurse's station. The Activity Director walked past Resident #D and spoke to the</p>		<p>IV. The Director of Nursing or designee will audit residents with continuous oxygen orders to ensure that their oxygen, if ordered as a continuous treatment, is necessary and effective for the residents upon admit, with a change in condition and weekly for 30 days. The Director of Nursing or designee will audit 2 residents per unit weekly at random intervals to ensure oxygen ordered is in place. The results of the audits will be presented monthly to the Performance Improvement meeting to determine when the frequency of the audits may be reduced however, an audit will continue. Date of completion: September 23, 2015</p>				

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	<p>other three residents sitting in the dining area. Neither staff replaced the oxygen tubing for the resident.</p> <p>During an observation on 08/26/2015 at 11:16 A.M., the Activity Director carried a chair to the front of the small dining area and sat down beside Resident #D. The nasal cannula was visibly hanging off of the resident's right ear. She did not replace the oxygen tubing.</p> <p>During an observation on 08/26/2015 at 11:17 A.M., LPN #15 walked past Resident #D and continued down the hallway towards the nurse's desk. LPN #17 was walking past Resident #D, stopped to check on the resident and placed the nasal cannula back on the resident face.</p> <p>During an observation on 08/26/2015 at 11:19 A.M., Resident #D's nasal cannula was not in the resident's nasal passages. LPN #15 and CNA #14 were placing residents in the dining area, where Resident #D was sitting, for lunch. Neither staff replaced the oxygen tubing for the resident.</p> <p>During an observation on 08/26/2015 at 11:24 A.M., Resident #D's head was hanging down with the edge of her brow resting on the edge of the table and her</p>			

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	<p>chin resting on the left arm of the wheelchair. The resident's nasal cannula was laying on the resident's legs.</p> <p>During an observation on 08/26/2015 at 11:27 A.M., CNA #14 woke up Resident #D and asked her if she was "doing ok", but did not replace the resident's nasal cannula.</p> <p>During an observation on 08/26/2015 at 11:28 A.M., LPN #15 walked past Resident #D and continued walking to the nurse's desk without replacing the oxygen.</p> <p>During an observation on 08/26/2015 at 11:32 A.M., CNA #6 walked up to Resident #D and placed the resident's nasal cannula back on her face.</p> <p>The clinical record for Resident #D was reviewed on 08/26/2015 at 10:42 A.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, cerebrovascular accident, dementia, manic depression, psychotic disorder, schizophrenia, and hypertension.</p> <p>The physician's order, dated 04/14/2015, indicated Resident #D was to have oxygen therapy at 2 liters per minute by nasal cannula continuously. The</p>			

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F 0329 SS=D Bldg. 00	<p>resident's condition for oxygen therapy was shortness of air.</p> <p>The care plan, dated 04/15/2015, indicated Resident #D had a diagnosis of COPD (Chronic Obstructive Pulmonary Disease). The interventions for COPD included, but were not limited to, "Administer medications as ordered, monitor for signs and symptoms and give oxygen as ordered."</p> <p>The MDS (Minimum Data Set) assessment was reviewed on 08/26/2015 9:26:25 AM. The quarterly MDS assessment, dated 07/24/2015, indicated Resident #D was severely cognitively impaired.</p> <p>3.1-47(a)(6)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any</p>						

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	<p>combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to adequately monitor the signs and symptoms of behaviors related to contemporary psychotropic agents for 1 of 5 resident's reviewed for unnecessary medications. (Resident #F)</p> <p>Findings include:</p> <p>During an observation on 08/24/2015 at 9:26 A.M., Resident #F was sitting in a wheelchair in the 300 hallway by the shower room door. The resident's right leg was off the foot peddle and hanging between the two foot peddles with the tip of the resident's toes touching the floor.</p> <p>The resident's head was hanging down to his chest.</p> <p>The clinical record for Resident #F was reviewed on 08/24/2015 at 9:39 A.M.</p> <p>The diagnoses included, but were not limited to, dementia, hypertension,</p>	F 0329	<p>F 329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>1. Resident # F was assessed and found to have no issues related to the alleged deficient practice. Resident #F was assessed and found that a GDR or discontinuation of any of his psychoactive medication would be contraindicated and the risks outweighed the benefits of discontinuing his medication simply due to alleged inappropriate documentation.</p> <p>2. All residents residing in the facility have the potential to be affected.</p> <p>3. Nursing staff were provided education regarding behavior management and documentation of behaviors present. Documentation on behavior flow sheets will be changed to reflect documentation by exception. To document by exception on the flow sheets will mean that if the behavior was not present, it will be left blank. Any documentation</p>	09/23/2015

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	<p>malaise, and anemia.</p> <p>Review of the "Psychological Consultation", dated 05/07/2015, indicated Resident #F was receiving "Contemporary Psychotropic Agents: Depo Provera 100 milligrams intramuscularly and Paxil 20 milligrams by mouth daily." The recommendations included "...related concerns to continue to be monitored..."</p> <p>Resident #F's Behavior Care Plan, which was initiated on 04/23/2015, indicated a potential to demonstrate physical behaviors of refusing care and hitting at staff. The interventions included, but were not limited to, "Administer and monitor the effectiveness of medications per physician order."</p> <p>Resident #F's Inappropriate Behaviors Care Plan, which was initiated 05/06/2015, indicated a potential to demonstrate sexually inappropriate behaviors. The interventions included, but were not limited to, "Administer and monitor the effectiveness and side effects of medications per physician's order."</p> <p>The "Behavior/Intervention Monthly Flow Records", dated May, June, July, and August, 2015, were reviewed on</p>		<p>on behavior flow sheets by the licensed nurse will be noted in the progress notes. Review of behavior documentation in nursing notes is a practice already in place during morning meeting. Side effect monitoring is already in place and charted by exception. During monthly behavior meetings, behavior monitoring sheets and behavior notes will be compared to ensure accurate documentation of behaviors. This information is shared with the Psychologist/Psychiatrist during the monthly behavior meetings. The notification of the Psychologist/Psychiatrist regarding medication side effects/monitoring and new behaviors have already been in place at the facility and will continue. Other departments were educated on use of behavior forms for behaviors that were not witnessed by nursing staff.</p> <p>4. The Social Services Director and Director of Nursing Services or designee will randomly audit for accuracy behaviors present on behavior monitoring flow sheet daily 5 of 7 days per week for 60 days, then 3 days per week for 60 days. Any incorrect information will be modified to reflect accurate documentation immediately. The results of the audits will be presented to the monthly Performance Improvement meeting to determine when the frequency of the audits may be</p>		

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	<p>08/24/2015 at 11:02 A.M. In the four month time frame reviewed, 39 assessment monitoring documentation spaces were left blank.</p> <p>Review of Resident #F's "Behavior/Intervention Monthly Flow Records" and comparison to the behavior progress notes on 08/24/2015 at 2:35 P.M., indicated the following:</p> <p>The "Behavior/Intervention Monthly Flow Record" , dated 08/10/2015 A.M., was left blank with no documentation, and on 08/10/2015 P.M., was marked with a zero with a line through it, indicating no behaviors occurred on that date.</p> <p>The progress note , dated 08/10/2015 at 5:39 A.M., which should be charted on the 08/09/2015 P.M. flow record, indicated, under behavior note type, Resident #F had "inappropriate sexual behaviors during morning care."</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 08/09/2015 A.M. and P.M., had zero's with a line through them indicating no behaviors occurred on that date.</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 06/26/2015 A.M.</p>		reduced however,an audit will continue indefinitely. Date of Completion: 9/23/2015	

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	<p>and P.M., had zero's with a line through them indicating no behaviors occurred on that date.</p> <p>The progress note, dated 06/26/2015 at 1808 (3:08 P.M.), indicated, under health status note, type Resident #F had "inappropriate sexual behaviors during collection of urine sample for testing."</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 05/22/2015 A.M. and P.M., had zero's with a line through them indicating no behaviors occurred on that date.</p> <p>The progress note, dated 05/22/2015 at 9:27 A.M., indicated, under behavior note type, Resident #F had "inappropriate sexual behaviors."</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 05/17/2015 A.M., was marked with a zero with a line through it, indicating no behaviors occurred on that date, and on 05/17/2015 P.M. was left blank with no documentation.</p> <p>The progress note, dated 05/17/2015 at 1910 (7:10 P.M.) indicated under behavior note type Resident #F had "inappropriate sexual and combative behaviors."</p>			

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	<p>The "Behavior/Intervention Monthly Flow Record", dated 05/12/2015 A.M., was left blank with no documentation, and on 05/12/2015 P.M., was marked with a zero with a line through it, indicating no behaviors occurred on that date.</p> <p>The progress note, dated 05/12/2015 0401, indicated, under behavior note type, Resident #F had "inappropriate sexual and aggressive behaviors."</p> <p>During an interview on 08/24/2015 at 1:33 P.M., LPN (Licensed Practical Nurse) #19 indicated all behaviors and interventions were documented on the "Behavior/Intervention Monthly Flow Record". The current month flow chart was kept in the MAR (Medication Administration Record) and documented in the A.M. and P.M. every day for Resident #89. When a progress note pertains to the behavior a code was to be placed on the "Behavior/Intervention Monthly Flow Record".</p> <p>During an interview on 08/24/2015 at 1:41 P.M., the SSM (Social Service Manager) indicated the team had met monthly to go over the resident's behaviors. During these meetings, only the "Behavior/Intervention Monthly Flow</p>			

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	<p>Record, new behavior forms and physician medication orders were reviewed for unnecessary medications.</p> <p>During an interview on 08/27/2015 at 9:37 A.M., the DON (Director of Nursing) indicated the "Behavior/Intervention Monthly Flow Record" was where nursing staff were to document behavior/intervention signs and symptoms. The DON indicated the A.M. documentation designated box on the flow record was from 7:00 A.M. to 7:00 P.M. and the P.M. documentation designated box on the flow record was from 7:00 P.M. to 7:00 A.M.</p> <p>During an interview on 08/27/2015 at 9:25 A.M., the DON indicated staff were to sign off when they give medications or treatments in the MAR (Medication Administration Record) or TAR (Treatment Administration Record), and document behaviors on flow records which are kept in the MAR.</p> <p>The DON indicated the NP (Nurse Practitioner) communicated with the nursing staff about the resident's status at the time of the visit, including resident behaviors seen by the NP or reported to the NP by other staff members.</p> <p>The current "Unnecessary Drugs" policy</p>			

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F 0353 SS=E Bldg. 00	<p>was provided on 08/26/2015 at 3:25 P.M. by the Executive Director. The policy was dated 04/28/2010. The policy indicated"...5. Medication are monitored to track progress toward therapeutic goals and to detect the emergency or presence of any adverse consequences...</p> <p>3.1-48(a)(3)</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p>			

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	<p>Based on observation, interview and record review, the facility failed to ensure sufficient staff was available to answer call lights in a timely manner and provide ADLs (Activities of Daily Living) for 6 of 37 residents interviewed (Resident #4, #80, #104, #149, #174, and #188), 2 of 3 families interviewed (Resident #11 and #26) and 6 of 8 staff interviews (Staff #51, Staff #52, Staff #53, Staff #54, Staff #55, Staff #56 and Staff #57)</p> <p>Findings include:</p> <p>During an interview on 08/20/2015 at 1:18 P.M., Resident #4 indicated she had to wait a long time for help when her call light is on.</p> <p>During a family interview on 8/20/2015 at 2:19 P.M., a family member for Resident #26 indicated they were concerned with the residents not having enough supervision during meals and the possibility of residents choking. During a family interview on 08/21/2015 at 9:45 A.M., the son for Resident #26 indicated he had visited and the residents were sitting in the lobby with no staff around. He also indicated he had to go outside the unit to get a staff member. He indicated Resident #26 had a wet brief because she couldn't get to the bathroom in time.</p>	F 0353	<p>F 353 SUFFICIENT 24-HOUR NURSING STAFF PER CARE PLANS I. Resident #80, Resident # 149, Resident #188 and Resident # 26 were assessed and found to have no adverse outcomes related to the alleged deficient practice. Unable to determine who Resident # 4, Resident # 104, Resident #174 are due to not being listed on the survey sample. Resident # 11's concern is not listed on the 2567. Resident#80 has a BIMS score of 7 which indicates severe cognitive impairment. Resident #174 has history of attention seeking behaviors and is not consistent in her answers regarding many aspects of her care. Resident # 188 is preparing to discharge to a group home setting and is expected to perform most ADL's himself in order to prepare him to be successful in the community. Resident # 188 stated that his needs are being met. II. All residents residing in the facility have the potential to be affected. III. The facility has a Corporate Recruiter working on behalf of the facility to assist with the hiring of licensed nursing assistants and licensed nurses. The facility has placed newspaper advertisements in newspapers in Bartholomew County and within 1 hour driving distance of the facility. The facility has held two separate Open Interview Days. The facility has mailed cards</p>	09/23/2015			

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	<p>During an interview on 08/21/2015 at 9:26 A.M., Resident #104 indicated she had urinary accidents while waiting for staff to answer her call light.</p> <p>During an interview on 08/21/2015 at 9:46 A.M., Resident #174 indicated there were not enough CNAs (Certified Nurses Aide). She indicated during evenings and at night she had to wait sometimes an hour to get help. Sometimes there was only one CNA for the entire hallway.</p> <p>During an interview on 8/21/2015 at 11:00 A.M., Resident #188 indicated there wasn't enough staff and if he wanted something he got it himself.</p> <p>During an interview on 08/21/2015 at 11:01 A.M., Resident #80 indicated there wasn't enough staff and had to wait a long time on all shifts to get her call light answered.</p> <p>During an interview on 08/21/2015 at 2:08 P.M., Resident #149 indicated there was not enough staff and had to wait up to an hour for assistance to go to the bathroom. She indicated this happened on all shifts.</p> <p>During confidential interviews on 8/24/2015, Staff #51 indicated it's almost impossible to get everything done during</p>		<p>about open positions to licensed nursing assistants and licensed nurses residing in the 47201 and 47203 zip codes on two separate occasions. The facility has placed flyers at colleges in Bartholomew County. The facility has placed flyers at nurse aide training centers in Bartholomew County. The facility has secured a contract with a licensed agency providing licensed nursing assistants. The facility has a referral drawing. The facility has placed online advertising on Indiana Career Connect, CareerBuilder, Indeed and other similar websites. The facility is assisting potential employees with the online portion of the application and hiring process. The facility has provided recruitment drawings to employees who refer potential employees. The facility has posted the number for Corporate Compliance and employees, residents and visitors can contact if they feel there are concerns in the facility without fear of retaliation. Incident regarding Staff # 53 stating that the residents could not be supervised due to not having enough staff which resulted in an altercation between residents could not be substantiated in that there have been no unwitnessed resident altercations. During review of the staffing the surveyors failed to add the fact there is a Reflections Coordinator and a Unit Manager</p>		

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	<p>the scheduled hours and residents had to wait to get help. Staff #51 indicated days were not staffed well and there were not enough CNAs on second shift.</p> <p>During a confidential interview on 8/25/2015 Staff #52 indicated the facility was having to use agency and a staff member was only as good as their hall partner. Staff #53 indicated staffing was a problem and it was impossible to get work done in the allotted time. Staff #53 also indicated the residents couldn't be supervised or cared for properly when there wasn't enough staff, as a result there had been resident to resident altercations.</p> <p>During a confidential interview 08/26/2015, Staff #54 indicated there was not enough staff to remain on the hall and be in the dining room during meal time. Staff #54 also indicated the required work could not be completed in the number of hours a staff member was scheduled. Staff #54 indicated residents had to wait to be cared for and there had been times continent residents had wet clothes and wet briefs because there were not enough staff to get them to the bathroom quick enough.</p> <p>During a confidential interview on 08/26/2015, Staff #55 indicated the facility was short staffed. Staff #55</p>		<p>who provide direct care to the residents residing on the Memory Units and that they were not counted in the staffing patterns for the Memory Units. IV. The Director of Nursing Services or designee will review 10 random resident and family interviews monthly to determine if resident's needs are being met timely. Negative responses will be followed up on through the grievance process. The Director of Nursing Services or designee will perform 10 random call light audits per month to determine timeliness of call lights being answered on all units. The results of the interviews and audits will be discussed during monthly Performance Improvement. Date of Completion: September 23, 2015</p>	

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	<p>indicated he/she attempted to care for residents with weaker bladders more quickly.</p> <p>During a confidential interview on 08/27/2015, Staff #56 indicated it was impossible to get the work done and care for the residents in the way they should be cared for. Staff #57 indicated staffing was bad and there were times the residents had to wait to have there call lights answered.</p> <p>During an interview on 08/26/2015 at 2:20 P.M. the Executive Director indicated the facility was short staffed for CNAs that was why she was using agency help.</p> <p>Review of the staffing schedule indicated one nurse was to pass medications and provide treatments for both Memory Garden and Memory Lane, the locked dementia units, from 7:00 A.M. to 7:00 P.M. and one CNA was assigned to each hall for day and evening shifts. Memory Garden had 16 residents and Memory Lane had 13 residents.</p> <p>Of the 143 residents residing in the facility, 122 residents required the assistance of one or two staff members for toilet use, according to the Resident Census and Conditions form completed</p>			

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F 0371 SS=E Bldg. 00	<p>by the Director of Nursing.</p> <p>3.1-17(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to follow appropriate hand washing guidelines for one of two kitchen observations. This had the potential to effect 142 out of 142 residents receiving meals from the kitchen.</p> <p>Findings include:</p> <p>During an observation of the kitchen with the DM (Dietary Manager) on 08/25/2015 at 11:08 A.M., DA (Dietary Aide) #12 was preparing pots of coffee and hot water for tea to take to individual floor units. In view of the DM, DA #12, wearing gloves, picked up a trash can lid off of the floor, placed it on a trash can, grabbed a pitcher, filled it with water, and placed it on a black cart still wearing</p>	F 0371	<p>F 371 FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY I. The Registered dietitian corrected DA # 12's behavior when it occurred and provided re-education to DA #12 immediately. DA#12 was instructed to remove his gloves and wash his hands. The items that DA #12 had touched were removed from the serving cart and replaced with clean items. II. All residents residing in the facility have the potential to be affected. III. All kitchen staff were inserviced regarding hand washing and infection control regarding kitchen sanitation, including not wearing gloves during unnecessary tasks such as preparing coffee. IV. The Dietary Manager or designee with perform random hand washing audits of 2 employees per day for 5 of 7 days per week for 30 days</p>	09/23/2015

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F 0372 SS=D Bldg. 00	<p>the same gloves. DA #12 then proceeded to get two pieces of foil cover two coffee pots with the foil and pushed the cart out of the kitchen. The DM indicated they did not have enough lids for the coffee pots and were using foil as a substitute, but did not direct the DA # 12 to wash her hands and change gloves.</p> <p>During an interview on 08/27/2015 at 2:35 P.M., the Dietician indicated gloves were used one time when having direct food contact.</p> <p>During an interview on 08/27/2015 at 2:40 P.M., Cook # 21 indicated, if someone had gloves on and picked something up off the floor, they should remove their gloves and wash their hands.</p> <p>Record review of the current " Waste Management for Foodservice " policy, provided by the ED (Executive Director) on 08/27/2015 at 2:53 P.M., indicated "...Wash hands after handling trash and trash receptacles.... "</p> <p>3.1-21(i)(3)</p> <p>483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.</p>		<p>then 1 employee per day for 90 days then 1 employee weekly indefinitely. Anydeficient practices will be corrected immediately . The results of the audits will be presented to the monthly Performance Improvement meeting to determine when the frequency of the audits may be reduced. Date of completion: September 23, 2015</p>	

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	<p>Based on observation, interview and record review the facility failed to dispose of garbage in a sanitary manner related to excessive loose garbage on the ground surrounding the dumpsters for one of one dumpster observations.</p> <p>Findings include:</p> <p>An observation of the garbage dumpsters was conducted on 08/27/2015 at 2:14 P.M. One brown dumpster for general garbage had a white bucket sitting behind it, 3/4 full of green liquid with brown debris floating in it. A rusted shovel was laying on the pavement beside the brown dumpster. A green dumpster near the brown dumpster was labeled for card board only. Nine used plastic gloves were scattered about the general area around both dumpsters along with an adult brief laying beside the green dumpster. Several palm size plastic pieces covered with dead dry grass were noted cluttered near and on the steps leading to the kitchen door entrance. Two metal strips, three feet long, were laying on the ground near the brown dumpster. Several palm size pieces of plastic and paper garbage were laying on a grassy area between the dumpsters and the building.</p> <p>During an interview on 08/27/2015 at</p>	F 0372	F 372 DISPOSE GARBAGE & REFUSE PROPERLY I. The items that were noted during the survey were discarded appropriately. The refuse company had emptied the trash within an hour of the surveyor discovering the items noted in the 2567. II. All residents residing in the facility have the potential to be affected. III. The Dietary and Housekeeping staff have been educated regarding the importance of ensuring that items placed in the trash dumpster do fall on the ground. The Maintenance Department Supervisor has contacted the refuse company to increase the number of times the trash is emptied from the dumpster per week. The refuse company supervisor has been contacted regarding the need for the driver to pick those items up off the ground and place them in the dumpster that have fallen during the dumping process. To ensure that garbage is disposed of properly, the Maintenance Department will ensure that garbage is not on the ground or any other inappropriate place in the AM prior to entering the building Monday through Friday. The Dietary Manager or designee will ensure that garbage is not on the ground or any other inappropriate place in the afternoons 7 days per week. The Housekeeping Manager or designee will ensure that garbage	09/23/2015

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F 0441 SS=D Bldg. 00	<p>2:55 P.M., the ED (Executive Director) indicated some staff were better about picking up around the dumpsters than others. She further indicated there was no schedule for keeping the area clean.</p> <p>Record review of the current "Waste Management for Foodservice" policy, provided by the ED on 08/27/2015 at 2:53 P.M., indicated "...Do not leave any trash along side or on top of the dumpster...."</p> <p>3.1-21(i)(5)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p>		<p>is not on the ground or any other inappropriate place in the evenings 7 days per week. IV. The Executive Director or designee will randomly inspect the area of the garbage dumpster 3 times per week for 30 days. The results of the inspections will be presented at the monthly Performance Improvement meetings. The Performance Improvement Committee will determine when the frequency of the audits may be decreased. Date of Completion: September 23, 2015</p>		

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	<p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper infection control measures were followed by staff for 2 of 3 direct care observations (Resident #116 and #20) in that handwashing was not done at the proper times or for the required length of time and linens were not handled properly. (CNA #9, RN#10, Laundry Staff #13)</p> <p>Findings include:</p> <p>1. During an observation on 08/24/2015 at 10:02 A.M., CNA #9 gathered supplies from the linen closet then took the supplies to Resident #116's room. The CNA washed her hands appropriately, donned gloves, wet a washcloth, lowered</p>	F 0441	<p>F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>1.Residents have been assessed for signs of adverse effects and none were noted. RN # 10 and CNA # 9 have received education regarding proper hand washing techniques and maintaining sanitary techniques during incontinence care and dressing changes. II. All residents residing in the facility have the potential to be affected. III. Facility staff have been educated regarding hand washing and infection control practices per facility policy, including transportation of linens throughout the facility. Facility staff will complete skill competency no less than yearly. Newly hired facility staff will receive education and complete skill competency. Licensed</p>	09/23/2015

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	<p>the head of the resident's bed, pulled down the resident's pants and undid the resident's brief. CNA #9 then assisted the resident onto his left side, removed the soiled brief, put the brief into a trashbag, soaped the wet washcloth, and wiped front to back cleaning the resident of feces. Without changing gloves, the CNA dried the resident with a new towel, put a new brief under the resident, put moisture barrier cream on her gloves, and smeared the cream onto the resident's buttocks. CNA #9 removed her gloves and donned new ones without washing her hands, secured the resident's new brief, pulled up the resident's pants, and positioned the resident comfortably. The CNA cleaned up the area, removed her gloves, and washed her hands appropriately before leaving the room with the bagged soiled linens.</p> <p>During an interview on 08/24/2015 at 10:16, CNA #9 indicated hands should be washed before and after care and anytime you move from one type of care to another, for example incontinence care to oral care.</p> <p>During an observation on 08/25/2015 at 10:03 A.M., RN #10 washed his hands for five seconds after administering medication to Resident #20. The RN then checked the TAR before returning to</p>		<p>Nursing staff will complete a skill competency regarding maintaining sanitary techniques during dressing changes upon hire and no less than yearly. Any concerns will be addressed. IV. The Staff Development Coordinator or designee will monitor for incontinence care and dressing changes performed in a sanitary manner and proper hand washing techniques with 1 aide and 1 nurse 5 days a week for 4 weeks, then 3 observations per week for 4 weeks then 1 observation a week for 4 weeks then monthly thereafter indefinitely. Any concerns will be addressed. The results of the audits will be reported monthly to the Performance Improvement Committee. The committee will determine if the frequency of the audits can be decreased. Date of completion: September 23, 2015</p>		

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	<p>Resident #20's room. RN #10 donned gloves, put supplies on the bedside table without putting a barrier down, and removed the resident's socks and shoes. The RN then removed the wool treatment from between the resident's toes, removed gloves, washed hands for four seconds, and donned new gloves. RN #10 put lotion onto his gloves and worked it into the resident's left foot and between toes. He pulled the new wool treatment from it's box, cut the wool with scissors, and placed the scissors onto the bedside table on top of papers and an inflatable seat cushion. The RN put the wool treatment between the resident's toes and covered the resident's left foot with a clean sock. RN #10 then put lotion onto his gloves and worked the lotion into the resident's right foot and between toes before removing the gloves. He washed his hands for three seconds, and donning new gloves. The RN pulled the wool treatment from it's box, cut it with the same scissors from the table, put the scissors back on the table, put the wool treatment between the resident's toes and covered the resident's right foot with a clean sock. RN #10 replaced the resident's shoes, picked up the wool treatment box and lotion and placed them on the resident's counter. He removed the gloves, picked up the contaminated scissors and placed them in his pocket.</p>			

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	<p>He washed his hands for the appropriate length of time this time.</p> <p>During an interview on 08/25/2015 at 10:13 A.M., RN #10 indicated hands were to be washed after gloves were removed and after a treatment was done. The RN also indicated hands should be washed for the length of two happy birthday songs, which the RN indicated was approximately a minute.</p> <p>During an interview on 08/25/2015 at 1:38 P.M., the DON (Director of Nursing) indicated hands must be washed for 20 seconds and should be washed before a treatment, any time gloves were removed, and if hands were visibly soiled. She further indicated inservices for handwashing were done on hire and education was provided immediately if needed.</p> <p>2. During an observation on 08/20/2015 at 12:51 P.M., Laundry Staff #13 had pushed a full, uncovered rack of clean residents' clothing down the Memory Lane Hallway and delivered clothing to four of the residents' rooms. While delivering the laundry, the Laundry Staff touched resident's cabinets and dressers. Laundry Staff #13 continued to push the uncovered rack of clean residents' clothing through the locked doors and deliver clothing to residents' in the</p>			

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	<p>Harmony Hallway. Laundry Staff #13 did not wash or sanitize hands throughout the observation.</p> <p>During an interview an 08/20/2015 at 1:10 P.M., Laundry Staff #13 indicated the facility's policy was to cover linens while transporting them through the hallways.</p> <p>The current handwashing policy, titled "Hand Hygiene/Handwashing" and dated 08/31/2011, was provided by the DON on 08/26/2015 at 3:30 P.M. and reviewed at that time. The policy indicated, "...Hand hygiene is to be performed:...After touching blood, body fluids, secretions, excretions and contaminated item, whether or not gloves are worn...between tasks and procedures on the same patient when contaminated with body fluids to prevent cross-contamination of different body sites...if moving from a contaminated-body site to a clean-body site during patient care...between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments...after removal of medical/surgical or utility gloves...." The policy also indicated, "...Rub hands together with vigorous friction for 20 seconds (The amount of time is [sic] takes to sing "Happy Birthday" through</p>			

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F 0514 SS=A Bldg. 00	<p>twice)...."</p> <p>3.1-18(l) 3.1-19(g)(2)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCES 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 interview and record review, the facility failed to maintain accurate and complete clinical information related to behavior monitoring and treatment administration documentation for 2 of 13 residents reviewed for accurate documentation. (Resident #F & #223) Findings include:</p> <p>1. The clinical record for Resident #F was reviewed on 08/24/2015 at 9:39 A.M. The diagnoses included, but were not limited to, dementia, hypertension,</p>	F 0514	F 514 RESIDENT RECORDS COMPLETE/ACCURATE/ACCES SIBLE I. Resident #223 no longer resides in the facility. Resident# F was assessed and found to have no issues related to the alleged deficient practice. Resident #F was assessed and found that a GDR or discontinuation of any of his psychoactive medication would be contraindicated and the risks outweighed the benefits of discontinuing his medication simply due to alleged inappropriate documentation. II.	09/23/2015			

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	<p>malaise, and anemia.</p> <p>Resident #F's Behavior Care Plan, which was initiated on 04/23/2015, indicated a potential to demonstrate physical behaviors of refusing care and hitting at staff. The interventions included, but were not limited to, "Administer and monitor the effectiveness of medications per physician order."</p> <p>Resident #F's Inappropriate Behaviors Care Plan, which was initiated 05/06/2015, indicated a potential to demonstrate sexually inappropriate behaviors. The interventions included, but were not limited to, "Administer and monitor the effectiveness and side effects of medications per physician's order."</p> <p>Review of Resident #F's "Behavior/Intervention Monthly Flow Records" and comparison to the behavior progress notes on 08/24/2015 at 2:35 P.M., indicated the following:</p> <p>The "Behavior/Intervention Monthly Flow Record" , dated 08/10/2015 A.M., was left blank with no documentation, and on 08/10/2015 P.M., was marked with a zero with a line through it, indicating no behaviors occurred on that date.</p>		<p>All residents residing in the facility have the potential to be affected. III. It is the policy of the facility that care is provided to residents to meet their highest potential. Nursing staff received education regarding documentation of ADL care provided and documentation of medication and treatments administered. ADL care sheet was modified to ensure clear and accurate documentation of ADLs provided. Documentation on behavior flow sheets will be changed to reflect documentation by exception. To document by exception on the flow sheets will mean that if the behavior was not present, it will be left blank. Any documentation on behavior flow sheets by the licensed nurse will be noted in the progress notes. Review of behavior documentation in nursing notes is a practice already in place during morning meeting. Side effect monitoring is already in place and charted by exception. During monthly behavior meetings, behavior monitoring sheets and behavior notes will be compared to ensure accurate documentation of behaviors. This information is shared with the Psychologist/Psychiatrist during the monthly behavior meetings. The notification of the Psychologist/Psychiatrist regarding medication side effects/monitoring and new behaviors have already been in place at the facility and will</p>				

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	<p>The progress note , dated 08/10/2015 at 5:39 A.M., which should be charted on the 08/09/2015 P.M. flow record, indicated, under behavior note type, "Resident [#F] had inappropriate sexual behaviors during morning care."</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 08/09/2015 A.M. and P.M., had zero's with a line through them indicating no behaviors occurred on that date.</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 06/26/2015 A.M. and P.M., had zero's with a line through them indicating no behaviors occurred on that date.</p> <p>The progress note, dated 06/26/2015 at 1808 (3:08 P.M.), indicated, under health status note, type Resident #F had "inappropriate sexual behaviors during collection of urine sample for testing."</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 05/22/2015 A.M. and P.M., had zero's with a line through them indicating no behaviors occurred on that date.</p> <p>The progress note , dated 05/22/2015 at 9:27 A.M., indicated, under behavior note type, Resident #F had "inappropriate</p>		<p>continue. IV. The Director of Nursing Services or Designee will audit ADL records, MARs and TARs for missing or incomplete documentation daily for 5 of 7 days per week for 60 days, then 3 of 7 days per week for 90 days. Any missing documentation will be immediately corrected to reflect care provided or refusal of care, whichever is accurate. The results of the audits will be presented to the monthly Performance Improvement Committee and the decision to decrease the frequency of the audits will be determined at that time. Date of Completion: 9/23/2015</p>				

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	<p>sexual behaviors."</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 05/17/2015 A.M., was marked with a zero with a line through it, indicating no behaviors occurred on that date, and on 05/17/2015 P.M. was left blank with no documentation.</p> <p>The progress note, dated 05/17/2015 at 1910 (7:10 P.M.) indicated under behavior note type Resident #F had "inappropriate sexual and combative behaviors."</p> <p>The "Behavior/Intervention Monthly Flow Record", dated 05/12/2015 A.M., was left blank with no documentation, and on 05/12/2015 P.M., was marked with a zero with a line through it, indicating no behaviors occurred on that date.</p> <p>The progress note, dated 05/12/2015 at 4:01 A.M., indicated, under behavior note type, Resident #F had "inappropriate sexual and aggressive behaviors."</p> <p>During an interview on 08/27/2015 at 09:25 A.M., The DON (Director of Nursing) indicated staff were to sign off when they gave medications or treatments in the MAR (Medication</p>			

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	<p>Administration Record) or TAR (Treatment Administration Record), and document behaviors on flow records which are kept in the MAR.</p> <p>The DON indicated the NP (Nurse Practitioner) communicated with the nursing staff about the resident's status at the time of the visit, including resident behaviors seen by the NP or reported to the NP by other staff members.</p> <p>2. Record review was conducted for Resident #223 on 08/24/2015 at 12:22 P.M. The Treatment Flow Sheet for July 2015 indicated:</p> <p>A. The order for Carrasyn V Gel Dressing, which was to be applied to the coccyx daily and as needed when soiled or dislodged, was not signed off in the TAR (Treatment Administration Record) by staff on July 1-4, 6-9, 15-17, 20-24, 26-27, and 29 of 2015.</p> <p>B. The order for Mepilex 4"x4" Dressing, which was to be applied to the left buttock daily and as needed when soiled or dislodged, was not signed off in the TAR by staff on July 1-4, 6-9, 12, 15-24, 26-27, and 29 of 2015.</p> <p>C. The order for Restore Calcium Alginate 2"x2", which was to be applied to the left buttock daily and as needed</p>			

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	<p>when soiled or dislodged, was not signed off in the TAR by staff on July 1-2, 5-8, 10-11, 13-14, 16-17, 19-23, 25-26, and 29 of 2015.</p> <p>D. The order for Restore Hydrocolloid 4"x4", which was to be applied to the coccyx and changed every three days and as needed, was not signed off in the TAR by staff on July 3, 21, 24, and 27 of 2015. The treatment ordered for July 6th was done on July 5, 2015.</p> <p>E. The order for Bacitracin 500 units/gram ointment, which was to be applied to the right ear two times a day, was not signed off in the TAR by staff on July 6, 12, 16-17, 21-23, 26-27 of 2015 for the A.M. application and July 18, 2015 for the P.M. application.</p> <p>During an interview on 08/27/2015 at 9:14 A.M., RN (Registered Nurse) #11 indicated when a treatment was done it was signed off in the MAR/TAR book. The RN further indicated that when looking to see if a treatment was done, the MAR/TAR was where they would look.</p> <p>During an interview on 08/27/2015 at 9:25 A.M., the DON (Director of Nursing) indicated that staff were to sign off after giving medications or doing</p>			

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	treatments in the MAR/TAR. She further indicated that treatments are considered done if they were charted in the Progress Notes, but that they were required to be documented in the MAR/TAR. 3.1-50(a)(1)(2)				