

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00158715, IN00158972 and IN00159175.</p> <p>Complaint IN00158715-Substantiated. Federal/State deficiencies related to allegations are cited at F 312, F 315, F 353 and F 514.</p> <p>Complaint IN00158972-Substantiated. Federal/State deficiencies related to allegations are cited at F 156, F 157, F 246, F 282, F 309, F 311, F 312, F 315, F 353, F 371, F 465 and F 505.</p> <p>Complaint IN00159175-Substantiated. Federal and State deficiencies related to the allegations are cited at F465.</p> <p>Survey dates: December, 1, 2, 3, 4, 5, 7, 8, 9, 10 & 11, 2014</p> <p>Facility number: 000135 Provider number: 155230 AIM number: 100266820</p> <p>Survey team: Leslie Parrett RN TC Diana Sidell RN Penny Marlatt RN Barbara Gray RN (December, 8, 9, 10 &</p>	F000000	<p>This Plan of Correction constitutes the centers Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana State Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.</p>	

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

TITLE

(X6) DATE

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

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F000156 SS=D	<p>11, 2014) Angel Tomlinson RN</p> <p>Census bed type: SNF: 7 SNF/NF: 90 Total: 97</p> <p>Census payor type: Medicare: 22 Medicaid: 39 Other: 36 Total: 97</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2 3.1.</p> <p>Quality review completed on December 19, 2014 by Cheryl Fielden, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in</p>						

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	<p>writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his</p>			

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	<p>or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review the facility failed to provide the discharge notice from skilled services (therapy) and appeal rights to a resident's family in order for them to be educated on the right to appeal the discharge for 1 of 3 residents who met the criteria for liability notices and beneficiary appeal (Resident #I).</p>	F000156	<p>F156</p> <p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident #'s POA was provided the discharge notice from skilled services (therapy) and appeal rights for most recent discharge from therapy and the process was discussed with her.</p> <p>How other residents having</p>	01/10/2015

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	<p>Finding include:</p> <p>Interview with Resident #I, family member #1 on 12/4/14 at 3:11 p.m., indicated the resident had fell at home and broke her left foot and had come to the facility for therapy services. Family member #1 indicated the resident was suppose to be rehab to home. Family member #1 indicated she felt Resident #I should have stayed in therapy longer to ensure she could ambulate and go home. Family member #1 indicated she had not received anything in writing why Resident #I was discharged from therapy or anything about appealing the discharge from therapy or she would have appealed the discharge.</p> <p>Review of the record of Resident #I on 12/8/14 at 2:25 p.m., indicated the resident's diagnoses included, but were not limited to, left foot fracture, diabetes, Coronary Artery Disease (CAD), peripheral artery disease and syncope.</p> <p>Interview with Resident #I, family member #3 on 12/8/14 at 11:10 a.m., indicated she felt like the resident should have remained in therapy so she could have been discharged to home. Family member #3 indicated the family was not given any option to appeal the resident's discharge from therapy.</p>		<p>thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</p> <p>All residents have the potential to beaffected. Executive Director conducted 100%audit of recent discharges from skilled services (therapy) to ensure dischargenotice from skilled services and appeal rights provided.</p> <p>What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot reoccur?</p> <p>Social Services Director/Memory CareFacilitator, Rehab Services Manager and Business Office Manager re-educated byExecutive Director by 1/10/15 on Discharge Notice from skilled services andappeal rights. Business Office Manager orDesignee will review daily to ensure discharge notice from skilled services andappeal rights provided timely.</p> <p>How will the corrective actions bemonitored to ensure they do not occur again?</p> <p>A DischargeNotice from Skilled Services CQI monitoring tool will be completed by the BOMor designee weekly x 6 weeks and monthly x 6 months to monitor for timely dischargenotice from skilled services and appeal rights. Audit tools will be submitted to the CQI committee and action plans willbe developed as needed if the threshold of 100% is not met.</p>		

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	<p>Interview with the Administrator on 12/11/14 at 9:15 a.m., indicated Social Services (S.S.) was not working at this time but the Administrator talked with S.S. and she indicated she remembered going over discharge from therapy with Resident #I's family. The Administrator indicated he was unable to find documentation except a blank discharge notice with the resident's name and the family members name on it with no date or any other information related to explanation for discharge from skilled services. The Administrator indicated he was unable to find further documentation indicating the family was informed of rights to appeal or the reason the resident was discharged from skilled services. The Administrator indicated Social Service was responsible to fill out the paperwork and ensure the family understands their rights and why the resident was being discharged from therapy. The Administrator indicated Resident #I was on skilled therapy services from 3/24/14 to 6/20/14. The resident's family should have received a notice of discharge and appeal rights on 6/18/14. The Administrator indicated Resident #I was on skilled therapy services from 9/12/14 to 10/6/14 and the family should have been notified on 10/4/14. The Administrator indicated Therapy was</p>			

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F000157 SS=D	<p>responsible to fill out a detailed explanation of Non coverage and then they give it to Social Services to go over with the families.</p> <p>This Federal tag relates to complaint IN00158972.</p> <p>3.1-4(a)</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</p>			

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	<p>specified in paragraph (b)(1) of this section.</p> <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 observation, interview and record review the facility failed to notify the physician for 10 days of a resident developing two large hemorrhoids for 1 of 3 residents reviewed for notification in a total sample of 31 (Resident #L).</p> <p>Finding include:</p> <p>During an observation on 12/2/14 at 12:00 p.m., CNA #2 and RN #1 transferred Resident #L with a hoier lift from his wheelchair to his bed to provide incontinence care. Resident #L had dry stool on his buttocks and anal area, his buttocks was red and he had two large hemorrhoids (swollen tissue) in his anal-rectal area. RN #1 indicated Resident #L always had a strong urine smell. RN #1 also indicated the resident did not have any treatment for the hemorrhoids, but she would notify the physician and get a treatment for the hemorrhoids.</p> <p>Review of the record of Resident #L on 12/8/14 at 10:40 a.m., indicated the resident's diagnoses included, but were</p>	F000157	<p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident #L's Physician was updated of the findings and new order was received for treatment to the affected area.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents have the potential to be affected. DNS or Designee conducted 100% audit of residents skin / peri area to assess for any necessary updates to the MD.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Nursing staff re-educated on Physician Notification Policy and importance of timely reporting of changes in resident condition/status. Facility Activity Report will be reviewed by Nurse Management Team / Weekend Nurse Manager daily to ensure physician updated timely with all change of conditions.</p> <p>How will the corrective actions be monitored to ensure they do not</p>	01/10/2015	

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	<p>not limited to, Parkinson disease, arthritis, depression, insomnia, hypertension and degenerative joint disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #L dated, 10/12/14, indicated the following: transfer- extensive assistance of two people, walk in room- did not occur, toilet use- extensive assistance of two people, personal hygiene- including brushing teeth and washing face- extensive assistance of two people, urinary incontinence- frequently incontinent, bowel incontinence- frequently incontinent.</p> <p>Interview with RN #1 on 12/9/14 at 11:30 a.m., indicated she forgot to notify the physician of Resident #L's hemorrhoids to get an treatment. RN #1 indicated she would report it to LPN #1 who was caring for Resident #L today.</p> <p>During observation of Resident #L on 12/9/14 at 11:55 a.m., CNA#3 and CNA #6 transferred the resident from his wheelchair to his bed with a hooyer lift . The resident's pants were wet with urine and he was continuing to have a bowel movement during the incontinence care. The resident had two large hemorrhoids in the anal-rectal area.</p>		<p>occur again?</p> <p>APhysician Notification CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor for timelyPhysician notification when a resident has a change in condition/status. Audit tools will be submitted to the CQIcommittee and action plans will be developed as needed if the threshold of 100%is not met.</p>	

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	<p>Interview with Resident #L on 12/11/14 at 10:00 a.m., indicated his bottom was sore.</p> <p>Interview with LPN #1 on 12/11/14 at 10:10 a.m., indicated RN #1 had not reported to LPN #1, that Resident #L had hemorrhoids. At this time LPN #1 reported to LPN #3, who was caring for Resident #L and she immediately called the physician and notified him of the resident's hemorrhoids.</p> <p>The physician telephone order for Resident #L dated, 12/11/14 at 10:30 a.m., indicated Resident #L was ordered a sitz bath every day and as needed, (name of hemorrhoid ointment) to hemorrhoids three times a day and as needed and colonoscopy at the local hospital on 12/22/14 at 8:30 a.m. This indicated the resident went 10 days without notification the physician or treatment for hemorrhoids.</p> <p>The Resident change of condition policy provided by the Director of Nursing Services (DNS) on 12/4/14 at 3:20 p.m., indicated the nurse in charge was responsible for notification to the physician, prior to the end of their assigned shift, when a significant change in the resident's condition is noted.</p>			

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F000246 SS=D	<p>This Federal tag relates to complaint IN00158972.</p> <p>3.1-5(a)(2)</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation, interview and record review the facility failed to provide a call light for residents to ask for assistance for 2 of 3 residents reviewed for call light provided (Resident #W and Resident #L).</p> <p>Findings include:</p> <p>1.) During observation on 12/1/14 at 2:53 p.m., Resident #W was laying in bed awake. The resident's call light was tangled around the bottom of her bed on the floor out of the resident's reach. CNA #12 indicated Resident #W does not always use her call light, but the facility was suppose to provide the call light for her. CNA #12 was able to get the call light untangled and clipped it to the resident's blanket. CNA #12 indicated</p>	F000246	<p>What corrective action will take place for those residents found to be affected by the deficient practice? Resident #W was provided with her call light upon awareness. Resident #L was provided his call bell upon awareness and upon call light being repaired the call light was placed within resident's reach.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents that utilize the call light to notify staff of their needs have the potential to be affected by this deficient practice. DNS conducted 100% audit to ensure all call light cords are functioning and have a clip attached to them to aid in placement of the call light to ensure they remain in reach of the residents</p>	01/10/2015			

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	<p>she was unsure who assisted Resident #W to bed as she had just begun her shift.</p> <p>The Annual Minimum Data Set (MDS) assessment for Resident #W dated, 9/28/14, indicated the following: bed mobility- extensive assistance of two people, transfer- extensive assistance of two people, walk in room- extensive assistance of one person, dressing- extensive assistance of two people and toilet use- extensive assistance of two.</p> <p>2.) During observation on 12/8/14 at 9:52 a.m., Resident #L was sitting in his wheelchair with no call light available. There was a bell sitting on his bedside table out of reach of the resident. RN #1 came into the resident's bedroom and indicated his call light had been broke since she came on duty at 6:00 a.m. RN #1 agreed Resident #L was not able to reach the bell that the facility had provided until his call light was fixed. RN #1 handed Resident #L the bell and he rang it. RN #1 educated the resident to ring the bell if he needed any assistance. RN #1 indicated she would find out from maintenance when the call light would be repaired.</p> <p>Interview with the Maintenance Supervisor on 12/8/14 at 10:08 a.m., indicated he had fixed Resident #L's call</p>		<p>at all times when in their room.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>DNS re-educated staff by 1/10/15 on proper call light placement and to monitor for the location of the call light with every interaction with the resident to ensure within reach. Room rounds will be completed each shift by DNS or Designee to monitor for call light clips and proper placement.</p> <p>How will the corrective actions be monitored to ensure they do not occur again?</p> <p>A CallLight CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor for call light availability and proper placement. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

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F000282 SS=D	<p>light.</p> <p>The Quarterly MDS assessment for Resident #L dated, 10/12/14, indicated the following: transfer- extensive assistance of two people, walk in room- did not occur, toilet use- extensive assistance of two people, personal hygiene- including brushing teeth and washing face- extensive assistance of two people, bathing- extensive assistance of two people, urinary incontinence- frequently incontinent, bowel incontinence- frequently incontinent.</p> <p>This Federal tag relates to complaint IN00158972.</p> <p>3.1-3(v)(1)</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.</p> <p>Based on interview and record review the facility failed to follow the plan of care to notify a resident's family of refusal of medications for 1 of 31 residents reviewed for plan of care (Resident #I).</p> <p>Finding include:</p>	F000282	<p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident #'s family is being notified the day the resident refuses medications.</p> <p>How other residents having the potential to be affected by the</p>	01/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/11/2014
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
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	<p>Interview with Resident #1 family member #1 on 12/8/14 at 11:10 a.m., indicated the family had requested to be notified when Resident #I refused medications. Family member #1 indicated they want to notified of refusal of medications so they could come to the facility and encourage the resident to take her medications. Family member #1 indicated they felt that the resident's medications were important for her health. Family member #1 indicated in October 2014 the resident refused several medications and she was unaware and not notified until the next day. Family member #1 indicated she had requested numerous times to be notified of the resident's refusal of medications and the facility was not doing this. Family member #1 indicated the family were able to get the resident to take her medications if they were given the opportunity to come in and encourage the resident.</p> <p>Review of the record of Resident #I on 12/8/14 at 2:25 p.m., indicated the resident's diagnoses included, but were not limited to, left foot fracture, diabetes, Coronary Artery Disease (CAD), peripheral artery disease, hypertension, depression and syncope.</p>		<p>same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this deficient practice if their individualized care plan is not followed timely. DNS re-educated staff on the Care Plan policy and availability of the Profile to ensure care plan is followed timely.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Nursing staff re-educated on the Care Plan policy and availability of the Profile to ensure care plan is followed timely. DNS or Designee will review the MAR daily to ensure physician and family member notified when resident refuses medication.</p> <p>How will the corrective actions be monitored to ensure they do not occur again? A Care Plan/ Profile CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor care plan being followed timely. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>		

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	<p>Review of the Medication Administration Record (MAR) dated, 10/9/14, indicated the resident refused the following medications: docusate sodium (bowel stimulant) 100 milligrams (mg) at 8:00 a.m., norvasc (antihypertensive) 5 mg at 8:00 a.m., plavix (antiplatelets) 75 mg at 8:00 a.m., gyburide (antidiabetic) 5 mg at 8:00 a.m., isosorb (antianginal) 30 mg extended release at 8:00 a.m., acarbose (antidiabetic) 25 mg at breakfast, vitamin B at 8:00 a.m., vitamin B 12 1,000 micrograms at 8:00 a.m., atenolol (beta blocker for angina) 75 mg at 8:00 a.m., namenda (anti- Alzheimer) 10 mg at 8:00 a.m., sertraline (antidepressant) 50 mg at 8:00 a.m., loratadine (antihistamine) 10 mg at 8:00 a.m. and acarbose 50 mg at lunch.</p> <p>The record of Resident #I indicated there were no vital signs documented for 10/9/14.</p> <p>The care plan for Resident #I dated, 8/25/14, indicated the resident had behavioral symptoms of refusing medications. The interventions included, but were not limited to, "if the resident repeatedly refuses medications, offer to let her speak to one of her daughters about this." "Call one of her daughters if resident continues to refuse so they may come to the facility if able."</p>			

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F000309 SS=D	<p>Interview with the Director of Nursing Services (DNS) on 12/9/14 at 2:00 p.m., indicated there was no documentation on 10/9/14, that Resident #I's family were notified of the resident's refusal to take her medications.</p> <p>The care plan policy provided by Clinical Education consultant on 12/11/14 at 2:30 p.m., indicated "It is the policy of this facility that each resident will have a comprehensive care plan developed based on comprehensive assessment." "The care plan will include measurable goals and resident specific interventions based on resident needs and preferences to promote the residents highest level of functioning including medical, nursing, mental and psychosocial needs."</p> <p>This Federal tag relates to complaint IN00158972.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>			
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	<p>Based on observation, interview and record review, the facility failed to provide treatment timely for a resident with hemorrhoids and failed to provide a resident with severe hyponatremia prompt medical attention, for 2 of 31 resident's reviewed for quality of care. (Resident #V and #L)</p> <p>Findings include:</p> <p>1. Resident #V's record was reviewed on 12/9/14 at 3:39 p.m. Resident #V was admitted to the facility on 9/22/14. Diagnoses included but were not limited to, Alzheimer's dementia, bipolar disorder, schizo affective disorder, asthma, psychotic seizures, chronic obstructive pulmonary disease, hypertension, history of syncope, history of falls, and diabetes mellitus.</p> <p>A "Comprehensive Metabolic Panel" laboratory report for Resident #V dated 9/24/14 at 10:58 a.m., indicated a repeated critical low sodium level of 114.</p> <p>An "Event Report" completed by LPN #1 for Resident #V dated 9/24/14 at 11:53 a.m., indicated an abnormal sodium level of 114. The report indicated the physician or family had not been notified.</p>	F000309	<p>What corrective action will take place for those residents found to be affected by the deficient practice? Resident #L's Physician was notified of the findings and treatment order obtained. Resident #V is no longer a resident of this facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents with changes in condition/status have the ability to be affected by this deficient practice if the Physician is not notified of the change in a timely manner. Nursing staff re-educated on the Policy on Physician Notification regarding changes in resident status as well as reporting of abnormal lab levels in order to receive any necessary orders. Facility Activity Report will be reviewed by Nurse Management Team / Weekend Nurse Manager daily to ensure physician updated timely with all change of conditions. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? DNS re-educated nursing staff by 1/10/15 on the Policy on Physician Notification regarding changes in resident status as well as reporting of abnormal lab levels in order to receive any necessary orders. Facility Activity Report will</p>	01/10/2015			

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	<p>A physician's note dated 9/25/14, indicated he had seen Resident #V for the first time since her arrival to the facility. He indicated laboratory values had been obtained and Resident #V showed significant hyponatremia to be present with a sodium level of 114. He indicated with a sodium level of 114 he would need to transfer her to the emergency room for immediate correction.</p> <p>A nurses note for Resident #V dated 9/25/14 at 9:48 a.m., indicated a physician's order was received to send Resident #V to the emergency room for hyponatremia. The facility nurse called a local emergency room and was directed by the emergency room staff to have the facility's physician call the hospital to have Resident #V be a direct admit to the hospital.</p> <p>A nurses note dated 9/25/14 at 10:30 a.m., indicated Resident #V had been directly admitted to a local hospital.</p> <p>An interview with the Director of Nursing Services (DNS) on 12/10/14 at 3:45 p.m., indicated if the facility received a repeated critical laboratory result the nurse would notify the physician.</p> <p>An interview with LPN #1 on 12/10/14 at</p>		<p>be reviewed by Nurse Management Team / Weekend Nurse Manager daily to ensure physician updated timely with all change of conditions. How will the corrective actions be monitored to ensure they do not occur again? A Physician Notification CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor for timely Physician notification when a resident has a change in condition/status or abnormal lab result in order to receive any necessary updates. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

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	<p>3:50 p.m., indicated she had completed the "Event Report" dated 9/24/14, for Resident #V regarding the sodium laboratory value. She indicated she had notified the Nurse Practitioner on 9/24/14, by telephone and handed her Resident #V's laboratory report when she arrived at the facility. She indicated it was near shift change and she left for the day.</p> <p>An interview with the Director of Nursing Services Specialist on 12/10/14 at 3:56 p.m., indicated no documentation was available the Nurse Practitioner had reviewed the laboratory report for Resident #V dated 9/24/14.</p> <p>An interview with the DNS on 12/10/14 at 5:19 p.m., indicated she could not recall if she was notified of Resident #V's laboratory report on 9/24/14, but did remember being notified on 9/25/14, and that Resident #V was being transferred to a local hospital.</p> <p>A telephone interview with the Nurse Practitioner on 12/11/14 at 11:38 a.m., indicated she did not recall reviewing a critical sodium laboratory value for Resident #V on 9/24/14, or in the month of September 2014. She indicated she always signed any laboratory reports she reviewed and documented her findings</p>						

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	<p>and her plan of care for the resident.</p> <p>The facility was unable to provide documentation the physician had been notified of Resident #V's laboratory results received by the facility on 9/24/14, until 9/25/14.</p> <p>Information documented at "http://www.mayoclinic.org" website on "Diseases and Conditions" indicated the following information on "Hyponatremia." "Hyponatremia is a condition that occurs when the level of sodium in your blood is abnormally low. Sodium is an electrolyte, and it helps regulate the amount of water that's in and around your cells... Hyponatremia signs and symptoms may include: nausea and vomiting, headache, confusion, loss of energy and fatigue, restlessness and irritability, muscle weakness, spasms or cramps, seizures, coma... A normal sodium level is between 135 and 145 millequivalents per liter (mEq/L) of sodium. Hyponatremia occurs when the sodium in your blood falls below 135 mEq/L....."</p> <p>The "Change of Condition" policy and procedure provided by the DNS on 12/10/14 at 5:15 p.m., indicated the following: "Policy-It is the policy of this facility that all changes in resident</p>						

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	<p>condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs. Procedure-...b. The licensed nurse will inform the attending physician, alternate physician, or Medical Director, of resident status as soon as possible before, during, or after the change of condition occurs or when resident crisis has been managed, and document the notification. c. The licensed nurse will notify the family/responsible party or resident change of condition and document notification. d. All nursing actions, physician contacts, and resident assessment information will be documented in the medical record. e. The Nursing Supervisor will be notified immediately of life threatening changes of condition. The Nursing Supervisor (or licensed nurse) will notify the Director of Nursing Services or Executive Director, as appropriate...."</p> <p>2.) During observation on 12/2/14 at 12:00 p.m., CNA #2 and RN #1 transferred the resident with a hooyer lift from his wheelchair to his bed to provide incontinence care. Resident #L had dry stool on his buttocks and anal area, his buttocks was red and he had two large hemorrhoids (swollen tissue) in his anal-rectal area. RN #1 indicated Resident #L always had a strong urine</p>			

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	<p>smell. RN #1 also indicated the resident did not have any treatment for the hemorrhoids, but she would notify the physician and get a treatment for the hemorrhoids.</p> <p>Review of the record of Resident #L on 12/8/14 at 10:40 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinson disease, arthritis, depression, insomnia, hypertension and degenerative joint disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #L dated, 10/12/14, indicated the following: transfer- extensive assistance of two people, walk in room- did not occur, toilet use- extensive assistance of two people, personal hygiene- including brushing teeth and washing face- extensive assistance of two people, urinary incontinence- frequently incontinent, bowel incontinence- frequently incontinent.</p> <p>Interview with RN #1 on 12/9/14 at 11:30 a.m., indicated she forgot to notify the physician of Resident #L's hemorrhoids to get an treatment. RN #1 indicated she would report it to LPN #1 who was caring for Resident #L today.</p>						

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	<p>During observation of Resident #L on 12/9/14 at 11:55 a.m., CNA#3 and CNA #6 transferred the resident from his wheelchair to his bed with a hooyer lift . The resident's pants were wet with urine and he was continuing to have a bowel movement during the incontinence care. The resident had two large hemorrhoids in the anal-rectal area.</p> <p>Interview with Resident #L on 12/11/14 at 10:00 a.m., indicated his bottom was sore.</p> <p>Interview with LPN #1 on 12/11/14 at 10:10 a.m., indicated RN #1 had not reported to me (LPN #1) that Resident #L had hemorrhoids. At this time I (LPN #1) reported it to to LPN #3 who was caring for Resident #L and she immediately called the physician and notified him of the resident's hemorrhoids.</p> <p>The physician telephone order for Resident #L dated, 12/11/14 at 10:30 a.m., indicated the resident was ordered a sitz bath every day and as needed, preparation H ointment to hemorrhoids three times a day and as needed and colonoscopy at the local hospital on 12/22/14 at 8:30 a.m. This indicated the resident went 10 days without treatment for hemorrhoids.</p>			

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F000311 SS=G	<p>The event report for Resident #L dated, 12/11/14 at 12:03 p.m., indicated the resident had two large external hemorrhoids and one on the rim of his anus, they were bright red and had a scant amount of red drainage.</p> <p>This Federal tag relates to complaint IN00158972.</p> <p>3.1-37(a)</p> <p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>Based on observation, interview and record review the facility failed provide a restorative ambulation program as recommended by the therapy department resulting in a resident to lose the ability to walk for a resident who was able to walk 80 feet with a walker at the time of discharge from therapy for 1 of 3 residents reviewed for specialized rehab in a total sample of 31 (Resident #I).</p> <p>Finding include:</p> <p>During observation and interview on 12/4/14 at 2:37 p.m., CNA #8 and CNA</p>	F000311	<p>What corrective action will take place for those residents found to be affected by the deficient practice? Resident #I is receiving physical therapy services to obtain highest practicable level of function.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents receiving Restorative services have the potential to be affected by this deficient practice. DNS conducted 100% audit of current Restorative caseload to assess for any decline in</p>	01/10/2015

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	<p>#9 provided incontinence care to Resident #I. CNA #8 indicated she was unsure when the last time the resident was provided incontinence as she had just started her shift. CNA #8 indicated Resident #I use to walk to the bathroom, but the resident had gotten progressively worse and now she could not walk. CNA #8 indicated the resident could only transfer with a gait belt from her bed to the wheelchair and pivot, but could no longer walk. Resident #I had feces smeared up and around her buttocks and the resident's brief was soaked with urine.</p> <p>Interview with Resident #I, family member #1 on 12/4/14 at 2:51 p.m., indicated the resident use to walk to the bathroom using a walker. Family member #1 indicated the staff never take the resident to the bathroom anymore. Family member #1 indicated the resident was suppose to be on a restorative nursing program for ambulation but the program was not done and now the resident had lost the ability to walk.</p> <p>Interview with Resident #I, family member #3 on 12/8/14 at 11:10 a.m., indicated the main concern the family had with the resident's care was the resident no longer ambulating. Family member #3 indicated the resident had fractured her left foot at home in</p>		<p>function and ensureresident's needs are being met and restorative services is being provided perplan of care.</p> <p>What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot reoccur?</p> <p>DNS re-educated nursing staff on theRestorative program and its intended purpose. Additional Restorative Aide scheduled to assist in the completion of theRestorative programs put into place by Therapy. DNS or designee will monitor daily restorative log to ensure residentsare receiving restorative services per plan of care.</p> <p>How will the corrective actions bemonitored to ensure they do not occur again?</p> <p>ARestorative Program CQI monitoring tool will be completed by the DNS or designeeweekly x 6 weeks and monthly x 6 months to monitor the Restorative Program forcompliance and resident participation. Audittools will be submitted to the CQI committee and action plans will be developedas needed if the threshold of 100% is not met.</p>				

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>February 2014 and came to the facility for rehabilitation. Family member #3 indicated the goal was for Resident #1 to return home after therapy was done. Family member #3 indicated in May 2014 when she was discharged from therapy the family was able to take Resident #1 out for lunch, family gathering and doctor appointments. Family member #3 indicated now the family was unable to take the resident to these things because she could not ambulate. Family member #1 indicated the resident was suppose to be in a restorative program to walk 80 feet six times a week and this was not done.</p> <p>Review of Resident #1 record on 12/8/14 at 2:25 p.m., indicated the resident's diagnoses included, but were not limited to, left foot fracture, diabetes, Coronary Artery Disease (CAD), peripheral artery disease and syncope.</p> <p>The therapy discharge summary dated, 5/28/14, (no time) indicated the resident required a front wheeled walker and minimal assistance for safe ambulation for 80 feet. Restorative nursing program recommended, staff to ambulate to and from the bathroom.</p> <p>Review of the restorative nursing program for Resident #1 dated, 5/13/14 to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>6/12/14, indicated the resident was suppose to be on a walking program six days a week 80 feet, with limited assist of one person and a rolling walker one time a day. The flowsheet indicated the resident walked 80 feet on 5/15/14, 50 feet on 5/16/14, 80 feet on 5/18/14, 80 feet on 5/20/14, 30 feet on 5/23/14, 30 feet on 5/25/14 and 40 feet on 5/31/14. This indicated the resident was not ambulated 8 days out of 17 days she was to be. The documentation indicated the resident was not ambulated in June 2014.</p> <p>The restorative nursing program for Resident #I dated July 1 to July 31, 2014, the resident walked 30 feet on 7/1/14, 40 feet on 7/3/14, 20 feet on 7/9/14, and between 2 feet to 15 feet the rest of July 2014.</p> <p>The restorative nursing program for Resident #I dated, August 1 to August 31, 2014, indicated the resident ambulated between 2 and 5 feet the entire month.</p> <p>The restorative nursing program for Resident #I dated, September 1 to September 30, 2014, the resident did not ambulate but was transferred 11 times.</p> <p>There was no documentation Resident #I participated in the restorative nursing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>ambulation program for the month of October 2014.</p> <p>The restorative nursing program for Resident #I dated, November 1, to November 30, 2014, indicated the resident's restorative program was changed and the resident was suppose to have a walking program 6 days a week to walk 20 feet with limited assistance of one and a rolling walker. The documentation indicated the resident did not ambulate during the month of November 2014, but was transferred 6 times.</p> <p>The restorative nursing program for Resident #I dated 12/1/14 to 12/9/14 indicated the resident did not ambulate, but was transferred 3 times.</p> <p>Interview with the MDS coordinator on 12/8/14 at 3:08 p.m., indicated she was over the restorative nursing program. The MDS coordinator indicated the facility had one restorative aide for the entire building. The MDS coordinator indicated the facility did not really have a restorative program at this time, but she had two aides she was going to be interviewing to get the program started.</p> <p>During observation on 12/8/14 at 4:55 p.m., Resident #I was transferred from</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>her bed to the wheelchair by CNA #10 and CNA #11 with a gait belt. The resident was not able to walk to her wheelchair or bare weight on her legs. The CNA's had to pivot the resident around and bring the wheelchair to the resident. The resident appeared completely held up by the CNA's.</p> <p>Interview with the restorative aide on 12/9/14 at 10:00 a.m., indicated Resident #I was able to ambulate in May 2014, but she was unable to ambulate with the resident 6 times a week because she was pulled to the floor to give resident care due to short staffing. The restorative aide indicated Resident #I began not being able to ambulate in September 2014 but was able to stand up with assistance from her wheelchair. The restorative aide indicated Resident #I did not receive her restorative ambulation program consistently. The restorative aide indicated at this time she had requested the therapy department to change her restorative program to sit to stand and was told to document the transfers. The restorative aide indicated she started being pulled to the floor in May 2014 to give resident care. The restorative aide indicated the facility had hired more CNA's and she was going to get the restorative program back in place.</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>Interview with the Therapy Manager on 12/9/14 at 11:18 a.m., indicated the restorative aide reported to him on 9/12/14, that Resident #I was not able to ambulate. The Therapy Manager indicated at that time the therapy department put her back in therapy and attempted to ambulate the resident. The Therapy Manager indicated the resident was able to walk between 10 to 20 feet. The Therapy Manager indicated Resident #I was discharged from therapy on 10/6/14 with a recommended ambulation restorative nursing program. When queried if he was aware that the facility did not have a restorative nursing program, the Therapy Manager indicated he was aware, but therapy was still required to generate a restorative program for residents.</p> <p>The Restorative Nursing Program policy provided by the Clinical Education consultant on 12/11/14 at 2:30 p.m., indicated the purpose was to provide a nursing program for residents who no longer need skilled therapy, but still have functional goals to be met or maintained through practice and repetition. The resident can also be placed on a program to maintain the ability to function at his or her optimal level within the given environment. These programs facilitate the use of skills that present but not</p>			

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F000312 SS=D	<p>utilized unless compensations or adaptations are provided and designed to foster maximum independence in functional activities. The restorative program included, but were not limited to, walking.</p> <p>This Federal tag relates to complaint IN00158972.</p> <p>3.1-38(a)(2)(B)</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.</p> <p>Based on observation, interview and record review the facility failed to assist a resident with personal hygiene and denture cleaning for 1 of 1 resident who met the criteria for Activities of Daily Living (ADL) for 3 residents reviewed for assistance with ADL's (Resident #L).</p> <p>Finding include:</p> <p>During observation on 12/2/14 at 11:49 a.m., Resident #L was asleep and his lower dentures fell to the floor out of his mouth. Resident #L's family member</p>	F000312	<p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident #L is receiving showers per preference, has his face cleaned as needed and his dentures cleaned daily. If resident #L misses shower per preference/schedule, shower will be offered by next day.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents requiring assistance with ADL's have the potential to be</p>	01/10/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/11/2014	
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>picked up the dentures and there was dried caked food inside of his dentures. The family member brought the resident's denture cup out of his bathroom and there were two denture cleaning tablets in the cup with no water. The resident's family member indicated she had put the tablets in there on 12/1/14 and had asked the staff to clean the resident's dentures as she was unable to stay late at the facility to clean the dentures. The family member indicated the facility staff frequently do not clean the resident's dentures for him before he goes to bed.</p> <p>During observation on 12/2/14 at 11:52 a.m., Resident #L smelled strong of urine. When queried why the resident smelled strong of urine. CNA #2 indicated the resident had a doctor's appointment on 12/1/14 and missed getting his shower.</p> <p>During observation and Interview on 12/2/14 at 12:00 p.m., Resident #L had food debris in his mouth, when queried why the resident had food debris in his mouth RN #1 indicated the resident should have mouth swabs in his room for the staff to clean his mouth but there were not any. CNA #2 and RN #1 provided incontinence care to the resident at this time, neither staff cleaned the resident's mouth. Resident #L's family</p>		<p>affected by this deficient practice. DNS conducted 100% audit to assess for unmetADL needs and care provided when warranted.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>DNS re-educated nursing staff by 1/10/15 on ADL care basics including ensuring resident showers are provided timely, mouth/denture care provided and residents assisted to be cleaned after meals to ensure necessary care and services are provided to the residents in need of assistance. Room rounds will be completed each shift by DNS or Designee to monitor for ADL needs being met.</p> <p>How will the corrective actions be monitored to ensure they do not occur again?</p> <p>An ADL Assistance CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to ensure proper ADL care is provided. Room rounds will be completed to ensure resident care needs are met. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>pushed the resident in his wheelchair to the dining room for lunch.</p> <p>During observation on 12/3/14 at 2:42 p.m., Resident #L was asleep in his recliner, the resident had dried food on his face.</p> <p>During observation on 12/4/14 at 3:45 p.m., Resident #L was asleep in his recliner, the resident had dried food on his face.</p> <p>During observation on 12/8/14 at 9:52 a.m., Resident #L was sitting in his wheelchair with dried food on his face and a thick white film in his mouth.</p> <p>During observation on 12/8/14 at 2:11 p.m., Resident #L was sitting in his recliner and had dried food on his face.</p> <p>Review of the record of Resident #L on 12/8/14 at 10:40 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinson disease, arthritis, depression, insomnia, hypertension and degenerative joint disease.</p> <p>The Quarterly Minimum Data Set (MDS) assessment for Resident #L dated, 10/12/14, indicated the following: transfer- extensive assistance of two</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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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
F000315 SS=D	<p>people, walk in room- did not occur, toilet use- extensive assistance of two people, personal hygiene- including brushing teeth and washing face- extensive assistance of two people, bathing- extensive assistance of two people, urinary incontinence- frequently incontinent, bowel incontinence- frequently incontinent.</p> <p>The careplan for Resident #L dated, 10/29/14, indicated the resident required extensive assistance with ADL, related to weakness, decreased mobility, Parkinson and arthritis. The interventions included, but were not limited to, provide showers on preferred and scheduled days and assist/provide oral care twice a day and as needed.</p> <p>This Federal tag relates to complaint IN00158715 and IN00158972.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(3)(C)</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</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview and record review the facility failed to assist two residents to the bathroom resulting in the residents becoming incontinent of bowel and bladder for 2 of 7 residents who met the criteria for urinary incontinence of 3 residents reviewed for incontinence care (Resident #L and Resident #I).</p> <p>Findings include:</p> <p>1.) During observation on 12/2/14 at 11:56 a.m., Resident #L had a brief on that was wet with urine and the resident smelled strong of urine. Interview with Resident #L's family member at this time indicated the resident frequently had urine soaked briefs on. The family member indicated they had been at the facility since 10:30 a.m., and no staff had come in to change the resident's brief. The family member indicated the staff changes Resident #L's brief after he eats his lunch.</p> <p>Interview with CNA #2 on 12/2/14 at 11:52 a.m., indicated Resident #L used a urinal around 10:00 a.m., when queried</p>	F000315	<p>What corrective action will take place for those residents found to be affected by the deficient practice? Resident #L and #I were provided incontinent care upon awareness of need. Resident #L and #I are being taken to restroom per resident request and plan of care.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All incontinent residents have the potential to be affected by this deficient practice. DNS conducted 100% audit to determine which residents are incontinent and staff updated with findings and care plans updated accordingly to ensure residents receive the necessary care for proper bowel and bladder elimination.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? DNS re-educated nursing staff by 1/10/15 on toileting residents using a Hoyer lift and the findings of residents that are incontinent and the care plans for residents to ensure residents receive the necessary care for proper bowel and</p>	01/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/11/2014
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
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	<p>about the resident smelling strong of urine, CNA #2 indicated yes the resident did smell of urine and it may be because he had a doctors appointment on 12/1/14 and missed getting his shower. CNA #2 checked the resident's brief and it was wet.</p> <p>During observation on 12/2/14 at 12:00 p.m., CNA #2 and RN #1 transferred the resident with a hooyer lift from his wheelchair to his bed to provide incontinence care. Resident #L had dry stool on his buttocks and anal area, his buttocks was red and he had two large hemorrhoids (swollen tissue) in his anal-rectal area. RN #1 indicated Resident #L always had a strong urine smell.</p> <p>Interview with Resident #L's family member indicated the resident was able to tell the staff when he needed to use the restroom. Resident #L's family indicated the staff did not take him to the bathroom anymore because he used the hooyer lift now and they could not get the lift in the bathroom.</p> <p>Review of the record of Resident #L on 12/8/14 at 10:40 a.m., indicated the resident's diagnoses included, but were not limited to, Parkinson disease, arthritis, depression, insomnia,</p>		<p>bladder elimination and theimportance of meeting toileting or incontinent care needs in a timely manner. Room rounds will be completed each shift byDNS or Designee to monitor that residents receive bowel and bladder care perresident preference and plan of care.</p> <p>How will the corrective actions bemonitored to ensure they do not occur again?</p> <p>AnIncontinent Care/ Toileting CQI monitoring tool will be completed by the DNS ordesignee weekly x 6 weeks and monthly x 6 months to monitor incontinentresidents for toileting and/or incontinent care is provided in a timely mannerincluding those requiring a Hoyer lift for toileting needs. Audit tools will be submitted to the CQIcommittee and action plans will be developed as needed if the threshold of 100%is not met.</p>		

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>hypertension and degenerative joint disease.</p> <p>The Annual Minimum Data Set (MDS) assessment for Resident #L dated, 4/12/14, indicated the resident required extensive assistance of two people to use the toilet. The resident was frequently incontinent of urine and occasionally incontinent of his bowels.</p> <p>The Quarterly MDS assessment for Resident #L dated, 10/12/14, indicated the following: transfer- extensive assistance of two people, walk in room- did not occur, toilet use- extensive assistance of two people, personal hygiene- including brushing teeth and washing face- extensive assistance of two people, urinary incontinence- frequently incontinent, bowel incontinence- frequently incontinent.</p> <p>The careplan for Resident #L with the last care conference dated, 10/29/14, indicated the resident was frequently incontinent related the use of a diuretic, non-ambulatory, Parkinson and Chronic Obstructive Pulmonary disease (COPD). The interventions included, but were not limited to, toilet every two hours and assist with incontinent care as needed.</p> <p>Interview and observation of Resident #L</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
---	--

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	<p>on 12/9/14 at 11:25 a.m., Resident #L was sitting in his wheelchair by the nursing station. Resident #L indicated he needed to go to the bathroom. This was reported to LPN #1. LPN #1 indicated CNA #3 was assisting another resident and she would tell her when she got done.</p> <p>During observation on 12/9/14 at 11:45 a.m., Resident #L's bedroom smelled of urine. Interview with the Director Of Nursing Services (DNS) at this time indicated she was unsure where the odor was coming from. Resident #L's recliner appeared to have a wet spot in the middle of the seat cushion. The DNS attempted to clean it up with a paper towel and the area was dry, the spot was a stain on the seat cushion. The DNS indicated the staff should take Resident #L to the bathroom when he tells them he needs to. The DNS indicated it did not matter if he used a hooyer lift for transfers, the resident should still be taken to the bathroom when he ask to go.</p> <p>During observation and interview on 12/9/14 at 11:55 a.m., CNA # 3 indicated she had changed Resident #L around 9:50 a.m., before she went on break and she would lay him down to change him at this time. When queried why she was not assisting the resident to bathroom like he</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>had requested, CNA #3 indicated the staff use to take him to the bathroom, but now that he uses a hooyer lift for transfers they did not. Resident #L indicated at this time he had already been incontinent of his bowels and bladder. The resident's pants were wet from urine. CNA #3 and CNA #6 transferred the resident from his wheelchair to his bed with a hooyer lift. The resident's pants were wet with urine and he was continuing to have a bowel movement during the care. The resident had two large hemorrhoids in the anal-rectal area and the resident's buttocks was pink with visible indentation marks from his brief and the hooyer pad.</p> <p>2.) During observation and interview with Resident #I on 12/4/14 at 10:10 a.m., Resident #I smelled strong of urine and feces. Resident #I indicated she was wet and needed to go to the bathroom. Resident #I indicated the staff knew she needed to go to the bathroom and she was not going to push her call light again for assistance.</p> <p>During observation on 12/4/14 at 2:02 p.m., Resident #I's bedroom smelled of urine and feces.</p> <p>During observation and interview on 12/4/14 at 2:37 p.m., CNA #8 and CNA</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/11/2014
NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#9 provided incontinence care to Resident #I. CNA #8 indicated she was unsure when the last time the resident was provided incontinence care as she had just started her shift. CNA #8 indicated Resident #I use to walk to the bathroom, but the resident had gotten progressively worse and now she could not walk. CNA #8 indicated the resident could only transfer with a gait belt from her bed to the wheelchair and pivot, but could no longer walk. Resident #I had feces smeared up and around her buttocks and the resident's brief was soaked with urine.</p> <p>Interview with Resident #I family member #1 on 12/4/14 at 2:51 p.m., indicated the resident use to walk to the bathroom using a walker. Family member #1 indicated the staff never take the resident to the bathroom anymore.</p> <p>Interview with Resident #I family member #2 on 12/4/14 at 3:11 p.m., indicated they had been at the facility and in the resident's bedroom since 11:30 a.m. Family member #1 indicated Resident #I smelled of feces and urine when they arrived at the facility. Family member #1 indicated no staff had changed the resident, checked on the resident or asked the resident if she wanted to get out of bed since they got to</p>				

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>the facility at 11:30 a.m.</p> <p>Interview with Resident #I's family member #3 on 12/8/14 at 11:10 a.m., indicated she had observed the facility leaving the resident soiled and wet in the dining room at meals three times. Family member #3 indicated the facility was suppose to change the resident every two hours and they did not. Family member #3 indicated she had come to the facility and the resident was sitting in her wheelchair with urine soaked clothes on and the pad in her wheelchair was soaked with urine and was dripping onto the floor.</p> <p>Review of the record of Resident #I on 12/8/14 at 2:25 p.m., indicated the resident's diagnoses included, but were not limited to, left foot fracture, diabetes, Coronary Artery Disease (CAD), peripheral artery disease and syncope.</p> <p>The Admission MDS assessment for Resident #I dated, 3/28/14, indicated the resident required extensive assistance of two people to use the bathroom, the resident was occasionally incontinent of urine and always continent of bowel.</p> <p>The Quarterly MDS assessment for Resident #I dated, 9/18/14, indicated the resident required extensive assistance of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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F000353 SS=E	<p>two people to use the bathroom, the resident was always incontinent of her bladder and bowels.</p> <p>The physical therapy discharge note for Resident #I dated, 5/28/14, (no time) indicated a recommendation for staff to ambulate the resident to and from the bathroom with contact guard assist and front wheeled rolling walker.</p> <p>The careplan with the last care conference date of 10/20/14, indicated the resident was incontinent at times due to dementia and decreased mobility. The interventions included, but were not limited to, assist with elimination.</p> <p>The physician recapitulation (recap) orders dated, December 2014, indicated the resident had an order to toilet the resident before and after lunch and before and after supper.</p> <p>This Federal tag relates to complaint IN00158715 and IN00158972.</p> <p>3.1-41(a)(2)</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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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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
	<p>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> <p>Based on observation, interview and record review, the facility failed to ensure adequate staffing to provide for the needs of the residents. This deficient practice may result in poor or limited care, such as remaining in soiled or wet clothing and/or briefs and strong odors of urine and feces and has the potential to diminish the quality of life for all 97 residents of the facility. (Resident #L and Resident #I)</p> <p>Findings include:</p> <p>1. Resident #L's clinical record was reviewed on 12/8/14 at 10:40 a.m. His diagnoses included, but were not limited to, Parkinson's disease, arthritis, depression, insomnia, hypertension and</p>	F000353	<p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Resident's #L and #I received care upon awareness of their needs.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents have the potential to be affected by insufficient staffing. Nursing Schedule monitored by DNS to ensure sufficient staffing available to ensure resident needs are met. Nursing staff re-educated on ADL care needs and the importance of meeting resident needs in a timely manner.</p> <p>What measures will be put into place or what systemic changes will</p>	01/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>degenerative joint disease. His most recent Minimum Data Set assessment, dated, 10/12/14, indicated the following: transfer- extensive assistance of two people, walk in room- did not occur, toilet use- extensive assistance of two people, personal hygiene- including brushing teeth and washing face- extensive assistance of two people, urinary incontinence- frequently incontinent, bowel incontinence- frequently incontinent.</p> <p>The careplan for Resident #L, with the last care conference dated 10/29/14, indicated the resident was frequently incontinent related the to use of a diuretic, non-ambulatory status, Parkinson's disease and Chronic Obstructive Pulmonary disease (COPD). The interventions included, but were not limited to, toilet every two hours and assist with incontinent care as needed.</p> <p>During an observation on 12/2/14 at 11:56 a.m., Resident #L had a brief on that was wet with urine and the resident smelled strongly of urine. In an interview with Resident #L's family member at this time, the family member indicated the resident frequently had urine soaked briefs on. The family member indicated they had been at the facility since 10:30 a.m. and no staff had come in to change</p>		<p>be made to ensure that the deficient practice doesnot reoccur? DNS re-educated nursing staff by1/10/15 on ADL care needs and the importance of meeting resident needs in atimely manner. DNS and Schedulerre-educated by Executive Director by 1/10/15 on Nursing Schedule being monitoredto ensure sufficient staffing available so that resident needs are met. Room rounds will be completed each shift byDNS or Designee to monitor that residents receive ADL care per residentpreference and plan of care. AdditionalRestorative Aide scheduled to assist in the completion of the Restorativeprograms put into place by Therapy. DNSor designee will monitor daily restorative log to ensure residents arereceiving restorative services per plan of care. How will the corrective actions bemonitored to ensure they do not occur again? A SufficientStaffing CQI monitoring tool will be completed by the DNS or designee weekly x 6weeks and monthly x 6 months to monitor personal care needs of the residents aremet timely and sufficient staffing provided to ensure sufficient staffing is scheduleeach shift. Audit tools will besubmitted to the CQI committee and action plans will be developed as needed ifthe threshold of 100% is not met.</p>	

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>the resident's brief. The family member indicated the staff changes Resident #L's brief after he eats his lunch.</p> <p>In an interview on 12/2/2014 at 11:42 a.m. with a family member of Resident #L the family member indicated, " The other day I put the light on three times. They (facility staff) are not supposed to turn the [call] light off, but they did. I put it on at 1 p.m. and they did not change him until 3 p.m. and he was wet the whole time. They [facility nursing staff] are short (staffed) during the week and weekends "</p> <p>In an interview on 12/2/14 at 11:52 a.m., CNA #2 indicated Resident #L used a urinal around 10:00 a.m. When queried about the resident smelling strongly of urine, CNA #2 indicated yes the resident did smell of urine and it may be because he had a doctor's appointment on 12/1/14 and missed getting his shower. CNA #2 checked the resident's brief and it was wet.</p> <p>During observation on 12/2/14 at 12:00 p.m., CNA #2 and RN #1 transferred the resident with a Hoyer lift from his wheelchair to his bed to provide incontinence care. Resident #L had dried stool on his buttocks and anal area, his buttocks was red and he had two large</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>hemorrhoids (swollen tissue) in his anal-rectal area. RN #1 indicated Resident #L always had a strong urine smell. RN #1 also indicated the resident did not have any treatment for the hemorrhoids, but she would notify the physician and get a treatment for the hemorrhoids.</p> <p>Interview with Resident #L's family member indicated the resident was able to tell the staff when he needed to use the restroom. Resident #L's family indicated the staff did not take him to the bathroom anymore because he used the Hoyer lift now and they could not get the lift in the bathroom.</p> <p>Interview and observation of Resident #L on 12/9/14 at 11:25 a.m., Resident #L was sitting in his wheelchair by the nursing station. Resident #L indicated he needed to go to the bathroom. This was reported to LPN #1. LPN #1 indicated CNA #3 was assisting another resident and she would tell her when she got done.</p> <p>During observation on 12/9/14 at 11:45 a.m., Resident #L's bedroom smelled of urine. Interview with the Director Of Nursing Services (DNS) at this time indicated she was unsure where the odor was coming from. Resident #L's recliner</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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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
	<p>appeared to have a wet spot in the middle of the seat cushion. The DNS attempted to clean it up with a paper towel and the area was dry, the wet spot was a stain on the seat cushion. The DNS indicated the staff should take Resident #L to the bathroom when he tells them he needs to. The DNS indicated it did not matter if he used a Hoyer lift for transfers, the resident should still be taken to the bathroom when he ask to go.</p> <p>During observation and interview on 12/9/14 at 11:55 a.m., CNA # 3 indicated she had changed Resident #L around 9:50 a.m., before she went on break and she would lay him down to change him at this time. When queried why she was not assisting the resident to bathroom like he had requested, CNA #3 indicated the staff use to take him to the bathroom, but now that he uses a Hoyer lift for transfers, they did not. Resident #L indicated at this time he had already been incontinent of his bowels and bladder. The resident's pants were wet from urine. CNA #3 and CNA #6 transferred the resident from his wheelchair to his bed with a Hoyer lift. The resident's pants were wet with urine and he was continuing to have a bowel movement during the care. Two large hemorrhoids were observed in the anal-rectal area and the resident's buttocks were pink with</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>visible indentation marks from his brief and the Hoyer pad.</p> <p>Interview with DNS on 12/9/14 at 2:02 p.m., she indicated she had the housekeeping staff conduct a deep cleaning in Resident #L's bedroom.</p> <p>2. Resident #I's clinical record was reviewed on 12/8/14 at 2:25 p.m. It indicated the resident's diagnoses included, but were not limited to, left foot fracture, diabetes, Coronary Artery Disease (CAD), peripheral artery disease and syncope.</p> <p>The Admission Minimum Data Set (MDS) assessment for Resident #I dated, 3/28/14, indicated the resident required extensive assistance of two people to use the bathroom, the resident was occasionally incontinent of urine and always continent of bowel.</p> <p>The Quarterly MDS assessment for Resident #I, dated 9/18/14, indicated the resident required extensive assistance of two people to use the bathroom, required extensive assistance of two people for hygiene needs, and the resident was always incontinent of her bladder and bowels. It indicated she did not walk.</p> <p>Resident #I's careplan, with the last care</p>						

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>conference date of 10/20/14, indicated the resident was incontinent at times due to dementia and decreased mobility. The interventions included, but were not limited to, assist with elimination.</p> <p>The physician recapitulation (recap) orders dated, December 2014, indicated an order to toilet the resident before and after lunch and before and after supper.</p> <p>In an interview on 12/2/2014 at 11:42 a.m. with a family member of Resident #L the family member indicated, " The other day I put the light on three times. They(facility staff) are not supposed to turn the (call) light off, but they did. I put it on at 1 p.m. and they did not change him until 3 p.m. and he was wet the whole time. They [facility nursing staff] are short (staffed) during the week and weekends "</p> <p>During observation and interview on 12/4/14 at 10:10 a.m., Resident #I smelled strongly of urine and feces. Resident #I indicated she was wet and needed to go to the bathroom. Resident #I indicated the staff knew she needed to go to the bathroom and she was not going to push her call light again for assistance.</p> <p>During observation on 12/4/14 at 2:02 p.m., Resident #I's bedroom smelled of</p>						

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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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
	<p>urine and feces.</p> <p>During observation and interview on 12/4/14 at 2:37 p.m., CNA #8 and CNA #9 provided incontinence care to Resident #I. CNA #8 indicated she was unsure when the last time the resident was provided incontinence care as she had just started her shift. CNA #8 indicated Resident #I use to walk to the bathroom, but the resident had gotten progressively worse and now she could not walk. CNA #8 indicated the resident could only transfer with a gait belt from her bed to the wheelchair and pivot, but could no longer walk. Resident #I had feces smeared up and around her buttocks and the resident's brief was soaked with urine.</p> <p>Interview with Resident #I family member #1 on 12/4/14 at 2:51 p.m., indicated the resident use to walk to the bathroom using a walker. Family member #1 indicated the staff never take the resident to the bathroom anymore.</p> <p>Interview with Resident #I family member #2 on 12/4/14 at 3:11 p.m., indicated they had been at the facility and in the resident's bedroom since 11:30 a.m. Family member #1 indicated Resident #I smelled of feces and urine when they arrived at the facility. Family</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>member #1 indicated no staff had changed the resident, checked on the resident or asked the resident if she wanted to get out of bed since they got to the facility at 11:30 a.m.</p> <p>Interview with Resident #1's family member #3 on 12/8/14 at 11:10 a.m., indicated she had observed the facility leaving the resident soiled and wet in the dining room at meals three times. Family #3 indicated the facility was suppose to change the resident every two hours and they did not. Family member #3 indicated she had come to the facility and the resident was sitting in her wheelchair with urine soaked clothes on and the pad in her wheelchair was soaked with urine and was dripping onto the floor.</p> <p>In an interview on 12/9/14 at 10:00 a.m., with CNA #7, she indicated the facility used to have two "restorative aides" (CNA's who work with residents to assist specifically with rehabilitative needs, such as ambulation, transfers, hygiene needs, based upon post-skilled therapy needs). She indicated since October, 2014, the facility only has one restorative aide. She indicated the facility has been short-staffed in the number of CNA's since approximately May, 2014. She indicated, "The facility was pulling both restorative aides to the floor."</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>CNA #7 indicated Resident #I was one particular resident that has declined in her abilities as a result of not receiving restorative services on a regular basis. She indicated in May, 2014, Resident #I was to walk six days per week. She indicated Resident #I was not able to perform the restorative program six days weekly because the :Restorative aides were pulled to the floor to do resident care instead of restorative." Therapy records indicated Resident #I was able to walk over 100 feet when discharged from therapy services to restorative services on 5/28/14. CNA #7 indicated by July, 2014, the resident was only able to ambulate with restorative services about two feet. She indicated by September, 2014, restorative staff was not able to work with her on a regular basis and had declined to the point of being unable to walk. She indicated this decline was reported to the therapy staff and the resident was begun in therapy services again. CNA #7 indicated the resident continues with some restorative services, but on an inconsistent basis, due to having only one restorative staff member and that person being pulled to the floor to work, instead of working on restorative services.</p> <p>In an interview with the Director of</p>						

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	<p>Nursing Services (DNS) on 12/4/14 at 8:45 a.m., she indicated the facility has experienced "some staffing issues over the last month or so."</p> <p>In an interview with LPN #2 on 12/4/14 at 1:50 p.m., she indicated, "We were really short handed for a while of CNA's, so they've had us nurses working extra as CNA's." She indicated the licensed nurses have had to work extra shifts in the capacity of CNA's to cover all shifts in the last month or so.</p> <p>In an interview with LPN #3 on 12/2/14 at 1:23 p.m., she indicated the facility has experienced issues in the last several months related to not having enough CNA's. She indicated this issue has caused the licensed nurses to pick up extra hours to cover as aides.</p> <p>In an interview with a family member of Resident #A on 12/4/14 at 3:30 p.m., the family member indicated he was concerned with lack of CNA staffing. He indicated one of the problems was his mother's room frequently smelled of urine and stool related to over-full trash and laundry bags. He indicated these over-full bags occurred on all shifts.</p> <p>In a review of the facility's "Resident Council Meeting" minutes from March to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>December, 2014, the following concerns were indicated:</p> <p>-March, 2014: "Residents feel that the quality of care is going down fast. (Name of 3 residents) not getting scheduled showers. (Name of a resident) not always getting the help she needs and aides are fussy with her. (Name of resident) state she is not getting any help with mouth care and there for (sic) is not wearing her dentures." No response from the Nursing Department was indicated for these concerns. "Residents upset that aides are calling in all the time." A response, dated 3/4/14, from the Nursing Department, indicated, "Staff inserviced about talking in front of residents concerning staffing issues."</p> <p>-April, 2014: One named resident and other unnamed residents's concern was not getting showers. One named resident desired to sleep later in the morning and to be assisted to bed right after supper. CNA's "always talking about their problems and scheduling issues." A named resident's bedside commode was not getting cleaned up after its use. The Nursing Department's response to these concerns were indicated to include inservicing or staff education on the above issues with "discipline to be given if continues" after the education; specific resident requests to be included in nursing documentation to keep nursing</p>			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>aware of the issues.</p> <p>-May, 2014: Several of the same issues cited in the April, 2014 were again listed which were the same named resident's request about arising times were not honored, the CNA's continuing to discuss personal problems and bedside commodes not being cleaned after use. The Nursing Department's response, dated 6/24/14, indicated an inservice to re-educate the entire nursing staff was held on 6/24/14 to address these issue.</p> <p>-June, 2014: Two named residents indicated they felt the CNA's were not as respectful as they should be. The Nursing Department's response, dated 6/24/14, indicated an inservice to re-educate the entire nursing staff was held on 6/24/14 to address these issue.</p> <p>-July, 2014: CNA's "are hurrying too much" with care/services. The Nursing Department's response, dated 8/15/14, indicated an inservice had been held (no date provided) to discuss the importance of ensuring resident's needs are met "and that the best gift they can give a resident is their time."</p> <p>-August, 2014: Residents "waiting too long to go to the bathroom. Nurse's won't help. (No further explanation provided.) The Nursing Department's response, dated 8/15/14, indicated the staff were inserviced on meeting the needs of the residents as soon as possible.</p>						

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>-September, 2014: CNA's respond to call lights, turn the call light off and tell the resident they will be right back and do not return; CNA's do not carry trash bags with them and are not replacing the bags in the trash cans when the trash can is emptied. The undated response from the Nursing Department indicated staff have been instructed to leave the call light on until the resident's needs are met as this serves as an auditory and visual reminder the resident's needs have not been met. Staff have been educated on where trash liners are located and are to replace liners after each use to prevent spillage/soiling of trash can and to decrease odors.</p> <p>-October, 2014: CNA's continue to turn off call lights and respond they will be right back, but then do not return to address resident's needs. Staff continue to not replace trash bags in trash cans when emptied. The Nursing Department's response, dated 10/22/14, indicated memos have been placed on the nursing units to remind staff to do these items.</p> <p>On 12-9-2014 at 8:40 a.m., the Administrator provided a copy of the " Resident Census and Conditions of Residents " document. (This document provides information on the types of care or care needs of the facility's residents.) It indicated the facility's census was 97.</p>						

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>This document indicated the following information:</p> <ul style="list-style-type: none"> -3 residents were independent for bathing activities, 61 residents required assistance of 1 or 2 persons for bathing and 33 residents were dependent for bathing. -3 residents were independent for dressing activities, 61 residents required assistance of 1 or 2 persons for dressing and 33 residents were dependent for dressing. -44 residents were independent for transferring activities, 30 residents required assistance of 1 or 2 persons for transferring and 23 residents were dependent for transferring. -73 residents were chairbound most or all of the time, 48 residents required assistance or an assistive device and 5 residents ambulated independently. No residents were indicated to be bedbound. -44 residents were independent for toilet use, 30 residents required assistance of 1 or 2 persons for toilet use and 23 residents were dependent for toilet use. 2 residents had urinary catheters. 77 residents were occasionally or frequently incontinent of urine and 65 residents were occasionally or frequently incontinent of stool. 10 residents were on urinary toileting programming and 10 residents were on bowel toileting programming. -86 residents were independent for eating 			

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>activities, 0 residents required assistance of 1 or 2 persons for eating and 11 residents were dependent for eating. 1 resident received tube feedings.</p> <p>-12 residents had a pressure ulcer of Stage II or greater, with 9 of those being acquired after admission to the facility. 86 residents received preventative skin care services.</p> <p>-43 residents had a diagnosis of dementia. 79 residents had signs or symptoms of depression. 39 residents had a psychiatric diagnosis. 3 residents had an intellectual and/or developmental disability. 5 residents had behavioral healthcare needs.</p> <p>-7 residents received hospice services. 1 resident received dialysis services.</p> <p>-65 residents received any type of psychoactive medications, including 19 residents receiving antipsychotic medications, 20 residents receiving antianxiety medications, 55 residents receiving antidepressant medication and 1 resident receiving a hypnotic medication. 17 residents received antibiotics. 56 residents were on a pain management program.</p> <p>In an interview on 12/8/2014 at 10:25 a.m. with the Director of Nursing Services (DNS), she indicated a family member of a previous resident did not address any concerns with her or the</p>			

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F000371 SS=E	<p>Administrator until after the resident had been moved to another facility in the last month. She indicated the family member shared with her, after the resident discharged, that the resident had been afraid there might come a time when there were no people (staff) here to take care of her.</p> <p>In an interview with the Administrator on 12/11/2014 at 12:09 p.m., he indicated he was unaware of any written policy regarding staffing. He indicated, " We staff (the facility) based on meeting the needs of the residents. "</p> <p>This Federal tag relates to Complaint IN00158715 and Complaint IN00158972.</p> <p>3.1-17(a) 3.1-17 (c)(4)</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</p> <p>Based on observation and interview the facility failed to ensure dishes were free of food particles when stored as clean, for</p>	F000371	<p>What corrective action will take place for those residents found to be affected by the deficient practice?</p> <p>Dietary including plates,</p>	01/10/2015

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374		
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	<p>2 of 2 observations, and failed to ensure the kitchen floor was free of a build up of gray and black substance for 3 of 3 observations. This had the potential to affect 97 of 97 residents residing in the facility.</p> <p>Findings include:</p> <p>The initial dietary observation was on 12/01/2014 at 10:10 a.m., with the Dietary Manager. The floor under cabinet legs and appliances, and next to the baseboard along the walls and door facings had dark gray and black areas.</p> <p>On 12/09/2014 at 2:21 p.m., with the Dietary Manager, 7 of 59 saucers had crumbs or a dried food substance on them, 1 dinner plate in a stack of 20 had a yellow dried, gummy substance on it. The floors were observed to be soiled with a black substance scattered in some areas and solid in other areas along the walls and baseboards, and around the legs of the counters, ranges, and refrigerators. The Dietary Manager indicated, on 12/09/2014 at 2:35 p.m., the floors are swept and mopped after meals, and housekeeping comes in every 3 to 6 months and power scrubs the floors. She indicated they are looking at replacing the floors.</p>		<p>bowls,baseboards, cabinet legs, appliances and floor was deep cleaned and is beingcleaned daily by dietary services.</p> <p>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</p> <p>All residents have the potential to beaffected by this deficient practice. Dietaryincluding plates, bowls, baseboards, cabinet legs, appliances and floor wasdeep cleaned and is being cleaned daily by dietary services.</p> <p>What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot reoccur?</p> <p>Dietary Manager re-educated dietarystaff by 1/10/15 on Dietary cleaning schedules, including plates, bowls,baseboards, cabinet legs, appliances and floor. Dietary Manager or Designee will inspect plates and bowls after eachmeal to ensure they are clean.</p> <p>DietaryManager or Designee will inspect baseboards, cabinet legs, appliances and floordaily to ensure cleanliness.</p> <p>How will the corrective actions be monitoredto ensure they do not occur again?</p> <p>ACleaning Schedule/ Dietary CQI monitoring tool will be completed by the DietaryManager or designee weekly x 6 weeks and monthly x 6 months to monitor</p>		

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>On 12/09/2014 at 4:47 p.m., the Executive Director, indicated they have plans to replace the floor, due to the age of the floor, said he thought it is the original floor, and cannot come clean. He provided a "Capital Budget Request" with a plan to replace the kitchen floor.</p> <p>During an interview with the Executive Director, on 12/10/14 at 9:00 a.m., he indicated he went in and looked at the kitchen floor, and talked to the Dietary Manager and Maintenance Supervisor; they had pressure washed the floors but didn't strip the wax off the floors, so he hired a professional crew to strip the old wax off and re-wax the floors.</p> <p>During an observation, on 12/10/2014 at 9:40 a.m., 8 of 20 maroon bowls had bits of white substance on the inside and outside of the bowls. The Dietary Manager indicated they had just been washed and had been placed on the trays to dry. The floors were observed to have gray and black buildups under cabinet legs and appliances, and next to the baseboard along the walls and door facings.</p> <p>This Federal tag relates to Complaint IN00158972.</p> <p>3.1-21(i)(3)</p>		<p>Dietary cleanliness including plates, bowls, baseboards, cabinet legs, appliances and floors. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview the facility failed to keep the environment free of odor and failed to keep residents wheelchair and bedside tables clean for 11 of 12 environmental observations.</p> <p>Finding include:</p> <p>Initial tour of the facility on 12/1/14 at 10:00 a.m., the D hallway smelled of urine, feces and malodorous odors. There were two trash and linen bins bulging full of trash and dirty linens. CNA #2 indicated the laundry and trash had already been taken out one time on this day. A large clear bag was laying on the floor, full of dirty linens in the shower room on the D hall.</p> <p>During observation on 12/4/14 at 10:10 a.m., Resident #I's bedside table was sticky and visibly dirty. Resident #I's bedroom smelled of feces and urine.</p> <p>During observation on 12/4/14 at 10:26 a.m., Resident #U was sitting in a broda</p>	F000465	<p>What corrective action will take placefor those residents found to be affected by the deficient practice?</p> <p>Resident #L's wheelchair cleaned androom deep cleaned upon awareness of issue. Staff re-educated to empty trash and laundry barrels prior to becomingtoo full to ensure lids would stay closed to prevent an odor source. Res #U Broda chair has been cleaned. Res #I room has been deep cleaned includingthe bedside table and is on the schedule for ongoing deep cleaning. Shower rooms were deep cleaned upon awarenessof the issue.</p> <p>How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?</p> <p>All residents have the potential to beaffected by this deficient practice. 100%audit of resident wheelchairs, Broda chairs and bedside tables were cleaned bynursing and housekeeping staff. Showerrooms were deep cleaned and will be cleaned and monitored daily and trash andlinen barrels</p>	01/10/2015

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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374			
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	<p>chair (specialty positioning chair) in her bedroom. The resident's broda chair had dried white substance on the arm rest cushions and down the leg rest.</p> <p>During observation on 12/4/14 at 2:31 p.m., Resident #U was sitting in the TV room and the broda chair had dried food and white substance on the foot rest.</p> <p>During observation on 12/7/14 at 5:42 p.m., the D hallway had a strong unpleasant odor.</p> <p>During observation on 12/8/14 at 9:52 a.m., Resident #L was sitting in his wheelchair in his bedroom, the wheelchair had food on his foot rest.</p> <p>During observation on 12/8/14 at 10:59 a.m., there was a strong smell of feces at the nursing station between C and D hallway. There were two linen and trash bags over full with dirty linen and trash located in the D hallway.</p> <p>During observation on 12/9/14 at 10:22 a.m., there was unpleasant odors of feces and yeast/fungal in the C hallway and D hallway. The trash and linen carts were full of soiled linen and trash in the C hallway and D hallway.</p> <p>During observation on 12/9/14 at 11:25</p>		<p>being emptied often to reduce odor by nursing and housekeeping staff.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>DNS re-educated staff by 1/10/15 on wheelchair cleaning schedule, linen and trash barrel use, shower room and resident room cleaning schedule and cleaning up spills timely including on resident bedside tables. Room rounds will be completed each shift by DNS or Designee to ensure that wheelchairs, Broda chairs, bedside tables and shower rooms are clean and that linen and trash barrels are emptied timely to reduce odor.</p> <p>How will the corrective actions be monitored to ensure they do not occur again?</p> <p>ACleaning Schedule/ Housekeeping CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor wheelchairs/Brodachairs, linen and trash barrels, shower and resident rooms including cleanliness of bedside tables. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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F000505 SS=D	<p>a.m., Resident #L was sitting by the nursing station in his wheelchair. The resident's wheelchair had dried food on the foot pedals.</p> <p>Interview with the Director of Nursing Services on 12/9/14 at 11:45 a.m., indicated wheelchair's were to be cleaned by CNA's during rounds.</p> <p>During observation on 12/9/14 at 4:10 p.m., Resident #U was sitting in the TV room in her broda chair. The resident's broda chair had dried food on the foot rest and padded arm rest.</p> <p>During environmental tour of C hallway and D hallway with the Maintenance Supervisor on 12/11/14 at 11:35 a.m., there were no odors observed or unclean resident equipment.</p> <p>This Federal tag relates to complaint IN00158972 and complaint IN00159175.</p> <p>3.1-19(f)</p> <p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings.</p> <p>Based on interview and record review, the facility failed to ensure the attending</p>	F000505	What corrective action will take placefor those residents found to be affected by the deficient practice?	01/10/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2014
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NAME OF PROVIDER OR SUPPLIER ROSEBUD VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2050 CHESTER BLVD RICHMOND, IN 47374
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	<p>physician was notified immediately of a critical sodium level of 114, resulting in a delay in treatment, for 1 of 6 residents reviewed for laboratory results. (Resident #V)</p> <p>Findings include:</p> <p>Resident #V's record was reviewed on 12/9/14 at 3:39 p.m. Diagnoses included but were not limited to, Alzheimer's dementia, bipolar disorder, schizoaffective disorder, asthma, psychotic seizures, chronic obstructive pulmonary disease, hypertension, history of syncope, history of falls, and diabetes mellitus.</p> <p>A "Comprehensive Metabolic Panel" laboratory report for Resident #V dated 9/24/14 at 10:58 a.m., indicated a repeated critical low sodium level of 114.</p> <p>An "Event Report" completed by LPN #1 for Resident #V dated 9/24/14 at 11:53 a.m., indicated an abnormal sodium level of 114. The report indicated the physician or family had not been notified.</p> <p>A physician's note dated 9/25/14, indicated he had seen Resident #V for the first time since her arrival to the facility. He indicated laboratory values had been obtained and Resident #V showed</p>		<p>Resident #V no longer resides at this facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?</p> <p>All residents with lab orders have the potential to be affected by this deficient practice. DNS conducted 100% audit of residents with current lab results to ensure all out of range results have been communicated to the Physician timely.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>DNS re-educated nursing staff by 1/10/15 on Physician Notification of abnormal/ critical lab results. Nursing Management / Weekend Nurse Manager will review labs daily to ensure lab results obtained and reported to physician timely.</p> <p>How will the corrective actions be monitored to ensure they do not occur again?</p> <p>A Physician Notification CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to monitor for timely Physician notification of all abnormal or critical labs. Audit tools will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>	

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	<p>significant hyponatremia to be present with a sodium level of 114. He indicated with a sodium level of 114 he would need to transfer her to the emergency room for immediate correction.</p> <p>A nurses note for Resident #V dated 9/25/14 at 9:48 a.m., indicated a physician's order was received to send Resident #V to the emergency room for hyponatremia. The facility nurse called a local emergency room and was directed by the emergency room staff to have the facility's physician call the hospital to have Resident #V be a direct admit to the hospital.</p> <p>A nurses note dated 9/25/14 at 10:30 a.m., indicated Resident #V had been directly admitted to a local hospital.</p> <p>An interview with the Director of Nursing Services (DNS) on 12/10/14 at 3:45 p.m., indicated if the facility received a repeated critical laboratory result the nurse would notify the physician.</p> <p>The facility was unable to provide documentation the physician had been notified of Resident #V's laboratory results received by the facility on 9/24/14, until 9/25/14.</p>				

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	<p>The "Change of Condition" policy and procedure provided by the DNS on 12/10/14 at 5:15 p.m., indicated the following: "Policy-It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs. Procedure-...b. The licensed nurse will inform the attending physician, alternate physician, or Medical Director, of resident status as soon as possible before, during, or after the change of condition occurs or when resident crisis has been managed, and document the notification. c. The licensed nurse will notify the family/responsible party or resident change of condition and document notification. d. All nursing actions, physician contacts, and resident assessment information will be documented in the medical record. e. The Nursing Supervisor will be notified immediately of life threatening changes of condition. The Nursing Supervisor (or licensed nurse) will notify the Director of Nursing Services or Executive Director, as appropriate...."</p> <p>This federal tag relates to Complaint IN00158972.</p> <p>3.1-49(f)(2)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure complete and accurate documentation regarding bathing for 1 of 3 residents reviewed for activities of daily living, including bathing and hygiene. This deficient practice has the potential to result in inaccurate documentation of a resident's care and/or care needs. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 12/9/14 at 12:51 p.m. Her diagnoses included, but were not limited to, dementia without behavioral disturbances, chronic pain, osteoarthritis, osteoporosis, anemia, high blood pressure</p>	F000514	<p>What corrective action will take place for those residents found to be affected by the deficient practice? Resident #A no longer resides at this facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. DNS conducted 100% audit to ensure residents shower/bathing needs are completed per preference schedule and documented accordingly.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p>	01/10/2015			

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	<p>and diabetes.</p> <p>Review of Resident #A's most recent Minimum Data Set (MDS) assessment, dated, was a Significant Change MDS. It indicated she was cognitively impaired. She did not ambulate and required extensive assistance of two or more persons for bed mobility and transfer from one surface to another. She required extensive assistance of one person with toileting needs and was usually incontinent of bowel and bladder. She required extensive assistance of two or more persons with hygiene and was dependent of two or more persons for bathing.</p> <p>Her care plan indicated she preferred to remain in bed and was to receive only bed baths and she required assistance with all activities of daily living.</p> <p>In interview with CNA # 5 on 12/11/14 at 9:57 a.m., she had worked with Resident #A. She indicated Resident #A received a complete bed bath twice weekly and a partial bed bath the other days of the week. She indicated the resident "always participated with the bathing for me." She indicated she did not recall any of the staff ever indicating this had been an issue for this resident.</p>		<p>DNS re-educated nursing staff by 1/10/15 on shower/bathing preference schedule and documentation requirement. Nursing Management /Weekend Nurse Manager will review daily to ensure shower/bathing preference schedule is completed and documented accordingly.</p> <p>How will the corrective actions be monitored to ensure they do not occur again?</p> <p>A Shower/Bathing CQI monitoring tool will be completed by the DNS or designee weekly x 6 weeks and monthly x 6 months to ensure shower/bathing needs completed per preference schedule and documented accordingly. Audit tool will be submitted to the CQI committee and action plans will be developed as needed if the threshold of 100% is not met.</p>				

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	<p>CNA # 5 indicated the documentation for bathing is conducted via the computer on a daily basis to indicate if the resident had a complete or partial bath or shower, as well as via a "shower sheet" on the days when a resident receives a complete bath or shower. She indicated the computer documentation offers a selection to indicate if a resident refuses bathing or is unable to bathe. She could not recall the exact choices offered on the computer system of why a resident might not bathe. She indicated the reason someone might not document something about bathing would be being forgetful.</p> <p>Review of Resident #A's bathing records for October, 2014 indicated beds baths were documented for 18 of 31 days. Review of Resident #A's bathing records for November, 2014 indicated bed baths were documented for 10 of 11 days.</p> <p>In an interview on 12/10/14 at 3:20 p.m., with the Director of Nursing Services (DNS), she indicated, "We have a problem with the staff not consistently documenting on the shower sheets when a resident gets a bed bath or a shower. The shower sheets and the Kiosk [computer system] does not always match. We have to do a better job with that [the documentation]." In an interview with the DNS on 12/11/14 at</p>						

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	<p>9:24 a.m., she indicated she could not locate any written shower sheets for Resident #A for October, 2014.</p> <p>This federal tag relates to Complaint IN00158715.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				